65 – Pt ē loin pain Radiating to umbilicus
- Nephrolithiasis.
- Medullary sponge (Pow se calli).
- Polycystic

66 – Pt ē Anti Ds Ab +ve.
anticardiolipin +ve. First episode of
DVT (leg) – Warfain 6 months
- Warfain 3 Months
- Warfain / Aspirin 3 Months
- Warfain / Aspirin 6 Months
- Warfain life long.

67 – Painless Hematuria, Nbr in urine 3000, WBC 34 Hb 18.
- Hydronephrosis ? (pow recall)

68 – Pneumonia ē ↓K, Rf.
- Macrolide
- Penicillin
- tetra

69 – Liver Abscess ruptured. Pleural effusion
Rf.

70 – Pt ē lower back pain At Night.
vertebra Collapse. Weight loss.
- MM
- Waldenstrom
- Paget
- MGus.

71 Hypokalaemic
met alkalosis. ē Semi-L, ↑ Aldosterone ↗
- Bartter
- Primary Hyperaldosteronism

①

2nd September 2020

① Cardiac catheterization of constrictive pericarditis Pt

② Pt on Digoxin develop rapid SVT
option
- Stop the drug
- reduce the dose
- verapamil

3 Pulseless VT management
- DC cardiovert thumb CPR
- Epinephrine
- shock & epinephrine

4 another ECG of SVT mangent Pt was hemodynamically unstable
- DC cardiovert
- Adenosine
- verapamil.

5 Pt c/o Inf wall MI BP 80-50 Pulse = 48
mangent
fluid
Atropine
Pacing.

6 Mycoplasma Pneumonia Rx.

7 In winter month of November Pt present c/o hematuria & on stain. Donath land stain true
- Paroxysmal Cold Hemoglobinuria
- PNH
- Autoimmune Hemolytic Anemia

(2)

8 Old lady ē Tachycardia, Thyroid Stēn Swelling . mangent

- Surgery
- RAI
- Thyroid drugs
- B. Blocker

9 2-3 QTN of Hypokalemia
ore energency mangment
ore ē cardiac arythia - Ca-gluconate
- fluid IDstin
ore ē Renal failure - dialysis
- antiarythic

10 Best fluid in Diarrhea
- N/S
- R/L
- D/S

11 Scenario low Ca
↑ Phosphate
high Alk. Pos
opthn
- CRF
- osteomalacia
- hypoparathyroidism

12 ore QTN of CP angle tumor

13 Thyroid Pt Surgery Doe of ē Rec tingling of hand & mouth & Stridor
- Recurrent laryngeal Nerve palsy
- HypoParathyroidism

14 Girl ē Bilateral vision, can't see White Board ē history of fall during climbing
- opthi
- CT Thorax
- Muscle Biopsy
- CPK - Single fibre EMG, - NCS

15 Old Man ē Joint pain, DIP involved now tender knee joint on presentation
Cal. Pyrophosphate
- Gout
- pseudogout
- Septic
- Osteo Arthritis

H/o peptic ulcer
In one day
Rx.
- Steroid
- Allopurinol
- Intraarticular steroid

16 History of 3 month Diarrhea. Now develop swollen joint painful
~~IBD~~ - IBD
- Whipple

17 14 year old Hypokalemic ē Normotensive
Failure to Thrive
- Bartter

18 Lady ē Amenorrhea loss of hair, leg swelling. Low LS, FSH
Cold intolerance
Hypothyroidism
- Polycystic ovarian
- Pregnancy
- Anorexia Nervosa.
- Bulimia

Tuesday

19 — Pt ē Precocious puberty.
Treatment
- GNRH
- steroid.

20 — High Aldosterone ē low renin.
Primary type Aldosteron
- RAS
- Liddle

21 — two Addison's QTN one Pt ē TB ē in H/o Adisonian crisis.

22 one lady ē H/o of cushing syndrom low K. ē the H/o of Proximal myopathy.

23 Pt ē H/o of dilated cardiomyopathy on Rx. ē H/o DM, HTN NAD Parental ē SOB, NO murmur, NO Sub, NO 3rd heart sound But Bilateral pedal edema ē raised JVP. dyspnea.
option
- CCF
-

24 — Pt DM, HTN, Atherosclerosis on drugs. Aspirin ē Thiazid diuretic BP = 150-90
- DM control
- HTN control
- cholesterol control
cholesterol - Normal range

25 QTN of vitreous detachment Rx option.
Difficult option ever can't memorise.

26 Electrician found unconscious GCS 3/15
Previous H/o alcoholism ALT. AST ↑
Renal failure due to
- Rhabdomyolysis
- Liver failure

27 Subarachnoid Bleed ē Previous H/o of PKD
develop Ras related to disease
- AR
- AS
- Mitral valve prolapse

28 Pt after diarrhea develop Anuria oligouria
on Metronidazole
Biopsy show Normal kidney
- ATN
- AIN

29 Diarrhea ē flagellate Strongyloid organ
Rx
- Albendazole
- Metronidazole
- I

30 Resistant Asthma Rx
- Oral steroids
- Mg sulphate
- Steroids

31 COPD pt on low dose Steroids
& Theophylline
- replace Theophylline ē Short acting Bronchodilator
- replace ē long acting
- Salmeterol / ICS high dose

32 Young Pt ē TCA poisoning (4 hours)
- Conservative
- Lavage

(6)

41 – Middle age lady ē fatigue.
Pruritis AMA +ve
- PBC
- PSC

42 – Known epileptic Boy ē poor dentition, Now developed Pneumonia, culture shows mixed organism. Rx
- Clindamycin
- Metro
- Macrolide.

43 – Male ē extra marital affair ē Dry cough fever, Sat. at Room air 91%. after 6 mt of cough 86%. saturation. CXR few infiltrate
- PCP
- Pneumonia
-

44 – Becker dis. Mode of Inheritance
- Autosomal dominant
- " Recessive
- X linked dominant
- X linked Recessive.

45 – Parkinson Pt ē Autonomic Neurofeature dizziness. light headache postural drop of 30.
- shy drager
- multi system atrophy

46 – obese Pt ē Hexadactyly hypogonadism.
- Lawrence Moon
- Kallman
- Prader Willi.

(7)

47 Pt c 5 HIAA level ↑
Cardiac abnormality.
- TS
- TR
- PS
- MS.

48 Scenario look like ~~MEN~~ ①
ZES
Investigation.
- Ca / PTH
- PTH
- Thyid.

49 Pt c hyperparathyroidism ↑ ACTH. & Mustle gastric ulcer.
- Primary hyperparathyroidism.
- APUDoma ①
- APUDoma 2a
- " 2b

50 Pt on fluoxetin + Amiodarone NOW T4 ↑ T3 Normal TSH Normal.
- stop Amiodaron
- stop fluoxetin
- start Anti thyid.

51 Young boy Sudden death family H/O.
- 1:8 CPR dC Plus
1 : 10000 epinephrin
1 : 3 CPR cardiac massage.
+ cardiac Drugs.

(8) 52 Girl ē frontotemporal headache for few wks
RT
Ex No H/o Nausea vomiting on & off.
But RT fixed dilated pupil.

- Migraine
- Cluster headache
- Post. Communicating artery aneurysm.

53 - young boy ē recurrent sinusitis ē RTI CXR No pleural pathology NO B/L hilar lymphadenopathy. clinical opacity starting upto Middle lobe lower lobe Plus mucoid impaction.

- CF
- ABPA.
- Kartagner

54 SAH → after 10days became deteriorated

- Hydrocephalus
- Vasospasm.

55 TBM scenario. CSF inferam of TBM

56 Pt on immunosuppressant - develop meningitis.
CSF RBS Normal
→ 2.1 protein - Lymphocyte predominant.
Ry → Antibacterial
- ganciclovir.
- vancicloxir.
- Anti biotic.

57 - QTN of Lupus Nephritis Glomerulo Nephritis

58 Ankylosing spondylitis.
Most common.
- Ant. uveitis
- Asymptomatic

59 Lupus Nephritis Ry. in female.
- Steroid
- cyclophosphamide for rem. survival
- MMF
- Methotrexate

60
- RA Pt. renal involvement
Investigate
Rectal biopsy for Amyloidosis

61
- Pt c mild periportal fibrosis. c Normal ALT/AST
Cause.
- Schistosomiasis.
- Caroli syn.
- alcoholic.

62
- Cirrhosis Pt c hypertrichosis
Hyperpigmentation Cause
PCT

63
- Cranial DI. After giving desmo.
↑ Osmolality + Urinary osmolarity
Both ↑.

64
- VT & SVT c Aberrant conduction
How to differentiate
- Concordance & discordance

H

72 Old man ē bone pain ē IgG ↑.
Gene Kappa chain ↑. IgM
Hb Normal. IgA] Normal
Paraprotein - Normal.
- MM
- MGUS
- Waldenstrom.

73 Pt ē Pheochromocytoma. surgery.
what complication he can develop.
- HTN
- MI
-

74 - ↓ Ca, Deranged RFT's. Met. bone aidsa
Rx - oral Ca
- IV calcium.
- Dialysis.
-

75 - ECG of pt ē Hypokalemia. Short Hx.
Ca. glucose
- Insulin
- fluid /

76 - Pt ē previous H/o of Achalasia, Best Rx.
3 year.
PPI
- surgery
- Botulinum.
- CCB
- Pneumatic dilator.

77 - Underlying cause of COPD Emphysema.
FEV/FVC ratio differences of obstructive picture
- Emphysema
- Obliterans. - Bronchitis

(18)

78 Hb - 7.6. Pt in shock.
Renal emia Pt
- fluid.
- Blood / IV line.
- Sangstekan tube
- Endoscopy.

79 One Pt ē H/o Upper GI bleeding.
Waiting for Endo. Best Rx.
- Terlipressin
- Stomach stabilizer
- β-blocker.

80 Lady after valine functio. presented ē severe epigastric pain tenderness. Ø / Any true available.
- perforated gastric ulcer
- pancreatitis
- cholecystitis.
MI

81 - Congenital adrenal hyperplasia. ē Enlarged clitoris & fused labia.
Primary Amenorrhea. What to check.
- 17-hydroxy
- 11-hydroxy.

82 - Insecticide. Dilation
Best Rx'
- Pralidoxime
- Atropine.

83 Snake bite - froth from mouth, drooping of eyelids, difficulty in breathing.
- Antivenom
- Mechanical ventilation
- Pharyngeal suction

(17)

84 – Mix. qtns of Wagner, good posture PAN.

85 – Many QTN of HUS, TTP. ITP

86 – Psoriatic arthritis, middle finger deviated, Xray scans - Nail do pitting Q.

87 – Needle Prick fro Hep. B pt - Not vaccinated before.
- HBIG
- Vaccine & HBIG.
- observe.

88 – Pt E Malabs low MCV, MCH, backache. Osteomalacia.
- Malabsorption.

89 – Myelodysplasia Best treatment of it
- Stem cell transplant
- Lenalidomide
- Transfu.
- Immunosuppression

90 – CML Typical scenario - Massive splen. cell count ↑. What is cause.
- CML & Blast crisis
- CML & Accelerated phase.

91 – Pt E enlarged spleen CBC shows Lymphocyte 50%. Neutr 40% Mono 10%.
- CML
- Chronic Myelo Monocytic leukaemia

92 – Pt & cervical Adenopathy - Non Adherent. Mobile, sore throat. Spleen mildly enlarge.
- atypical lymphocyte
- Bone marrow

(14)

93

— Pregnant female painful genital ulcer.
Raw & diffuse.
i Wrote
Treponemal smear.

94

— Pt c Hb 96PD. Presently c P. vivax again
again.
Primaquine 15mg BD for 15day
Primaquine 45mg in 4wk.

95

— Complicated falciparum Malaria.
I/v Artesunate
I/v Quinine
I/M Artesunate.

96

— Pt Blood culture report they asked about
Sensitivity of organism. it was for
meningitis.
- 60-70%.
- 90-100%. (Pow recall)
- 50-60%.

97

— Bulky mediastinum + Cervical LN.
Which cells you see in Hodgkin.
- Reed sternberg cell

98

— Hiv Pt on HAART Now Reed Sternberg.
- Indinavir

99 Pseudohypoparathyroidism
- Urinary CAMP ↓ in PTH.
Normal/low.

100 — QTN look like Sjogren syndrome. dry eye dry mouth.
But antibodies is opposite as NO Ro/NO LA but
Other:
- Thyroid peroxidase
- Anti JO
- SCL-70

(15) (1-1) _ Pt chased Antidepressant
Now on clozapine what ll you mark
- Xray chest
- CBC
- PLT
- ECG.

(1-2) _ On scenario of TTP. & on 7th day pt deteriorated, Done positive allergic. or leukocyte Ab.

(103) _ Banka ē H/o chest pain 3days.
Not controlled ē Hepri. & Nitrate.
Cardiac enzyme Raised. ST ↓↓.
- B-blocker IIIv
- CCB
- Angio
- Ant surgery.

(104) _ One COPD Pt ē Po2 60mmHg.
Most appropriate Management
- LTOT
- steroid
- LAB / ICS.

(105) _ Pt Ⓐ 20yrs with upper limb LMN sign ē hypothenar wasting lower limb UMN ē upgoing Plantar & Weak patchy sensory loss upto Nipple.
Cause.
- Friedrich Ataxia
- MND
- cervical myelopathy
- vit B12 ↓.
- syringo

16

106 Vit B_{12} ↓↓
MCV ↑ Anemia, vibration loss
- folate - B_{12} - Iron

107 TLC - 115,000 - PLT ↑↑
~~Anemia~~ MCV 105.
Retic ↑. Polychromasia.
cause.
- ineffective erythropoiesis
- B_{12}
- folate
- Myelodysplastic syndrome.

108 — Workup of Anemia in pregnancy.
- S. Ferritin
- Iron
- TIBC
- Transferin

109 Pt c Rash fever, STD, syphilis.
Rx
- Benzathine Penicillin
- Procain Penicillin
- Penicillin G

110 - Doxycycline.

111 one scenario of livestock man, complicated scenario - But look like Brucellosis

112 VWF scenario BT & APTT ↑.
PT Normal.
Pt c Intermittent family H/o of bleeding
young girl ↓ Na. abd. pain.
Investigation.
- CXR.
- USG
- Urinary porphyrin

(18) (123) DM pt ē fast infection.
on. antibiotic develop SiADH.
Case.

- Ofloxacin
- Ceftriaxone
- Cephalosporin-
-

(24) 2f wall MI. ē pace maker is

- Type ① heart block
- Type II mobitic type II
- Complete heart block.

(125) After cardiac transplantation - develop fever after 2 month.

- ganciclovir
- Varicol
-

erythromelalgia – improves on exposure to cold etc.
• elevation of extremity – Most common = essential thrombocythemia

1. A young patient with Narrow complex tachycardia (SVT) give ◊ IV Adenosine
2. For prophylaxis of roommate of pt wd meningococal menigits
B.rif+ meningococal vaccine tetravalent
3. One qs 'iv drug abuser with shoulder pain, o/e normal shoulder joint, cervical xray normal, with hiccups. Dx=? ◊ CT abdomen
4. Commonest cause of PUO –TB
5. Fear gripping near by objects - Temporal lobe epilepsy
6. Scenario with recurrent flushing & diarrhrea.. But also, typical findings of MS. ◊ carcinoid syndrome
7. Differentiating test between crohns and ulcerative colitis.. – serology
8. What goes in favour of ulcerative colitis and not in crohns.- circumferential involvement
9. 5 ASA compounds in UC ◊ reduce risk of colorectal carcinoma
10. Patient with ST elevation inferior wall MI ...sk was given...after 2hours patient still complaining of severe chest pain ...ECG ST elevations
• Rescue PCI
11. 90kg female with Amenorrhoea, hypertension and hirsuitism ◊ PCOS / cushing syndrome
12. Pt wd headache .bp 230/130. Papilledema..Chest clear.
A. Iv nitroprusside V/S Labetalol- ??
13. Dose of adrenaline in CPR?? ◊ 1mg every 3 min
14. Polymorphic erupted lesions on skin family history positive ◊ scabies
15. K/c of crohns develops hematuria and flank pain. Cause?
A. Hyperoxaluria leading to renal stones. — colitis.
16. Patient with A-FIB + severe abdominal pain + thumbprint sign on x ray ◊ ischemic colitis
17. Patient DM type 1 having family history positive. Father died of CRF. By what investigation we will assess his renal involvment.
A. Microalbuminuria
18. Pt develops skin pigmentation..had BL adrenalectomy.
A. Nelson syndrome. — post Adrenelectomy — Addison's — ACTH high.
19. Patient with lightheadedness Chest xray and ecg was normal ... Holter monitoring was advised what will it show — ??
A. svt B wencheback phenomena
20. Young male with history of Gerd..ogd showed multiple pyloric ulcers + short QT interval ◊ hypercalcemia
21. A patient had asystole 4 mins before your arrival. Cpr was started before you. On arrival what will you do.
#. Iv adrenaline 1mg
22. Alcoholic smoker with cough and sputum,hemoptysis weight loss CXR – RN shadow..His bronchoscopy and biopsy picture showed?? ◊ AFB
23. Diabetic tennis player collapsed --<> hypoglycemia — erythropoietin
24. A sports man took some drugs than his hb 19.3 If Hct > 50% — out from game
Hematocrit 58% he is at risk for Normal Hematocrit males = 42 ± 5
Rhabdomyosarcoma — ??
Hcc — Hemochromatosis ↑ Risk of HCC.
Rcc — erythropoietin → ↑ Arterial + venous thrombosis.
25. Alcoholic male with history of pancreatitis, epigastric pain which got severe in past two months. C.T abdomen shows

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Hematocrit 58% he is at risk for
Rhabdomyosarcoma
Hcc
Rcc
25. Alcoholic male with history of pancreatitis, epigastric pain which got severe in past two months. C.T abdomen shows cyst of size 7x8 cm and increased peritoneal fluid surrounding small gut loops. — ??
1. Acute pancreatitis
2. Adenoma pancreas
3. Pancreatic pseudocyst — ??
4. Metastatic ca
26. MCC of recurrent Myoglobinuria–mc cardle disease
27. MR + seizures + adenoma sebacicum – TS complex
28. Laborer chest pain -◊ pneumothorax
29. Cholecystitis senario.. What is best test to see obstuction of cystic duct...
1..Uss bilarry tree
1.. HIDA scan = Best.
30. Diet sushi + anemia (diaphlabothrium latum → Fe Def Anemia.
31. Feeling lump in throat withouy any difficulty in swallowing to liquid or solid
Globus hystericus
32. Flank pain and hematuria..xray normal..uS showed dialted pelvi calyceal system and multiple shadows.
Dx. Urate stones
B.cystine stone'

erythropoietin → ↑ Risk of HCC.
erythropoietin → ↑ Arterial + venous thrombosis.
Hemochromatosis
If Hct > 50%, — act from game
Normal Hematocrit males = 42 ± 5
— ??
essential thrombocythemia
Myelofibrosis
Myeloproliferative
Polycythemia
thrombocythemia
↳ lu-x — lucent = urate Xanthine
Secondary erythromelalgia
fibromuscular dysplasia affects which — Iliac
Tuberculous aneurysms involve.
Raynauds is most freq ass = headache — Migraine
Migrating thr superficial thrombosis
string of beads.

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Corrected Na= (in Hyperglycemia) Measure Na in Serum + 0.016 x (Glucose in serum - 100)2

Esophageal Manometry

33. Achalsia scenario ◊ manometry
34. GERD diagnostic ◊ 24hr pH monitoring
35. Emphymatous cholecystitis scenario — ?
36. Young boy with RBBB and some ectopics ◊ RV arrhythmogenic cardiomyopathy
37. Most common Portosystemic shunt ◊ gastric vein and esophageal vein [GaVE]
38. Definitive rx of HP syndrome ◊ liver transplant
39. Case of snake bite, now pulse is diminished + raised INR ◊ FFP + fasciotomy
40. One strong pulse alternate with one weak pulse in patient with dyspnea ◊ pulsus alternans
41. Scenario of Rheumatic fever ◊ ASO titer
42. Scenairo of rheumatic fever ◊ erythema marginatum
43. Serum sodium 124, RBS 700mg/dl ◊ corrected sodium 134 — ?? → 124 + 0.016 x (700 - 100) 124 + 0.016 x 600 124 + 9.6 = 134 — ??
44. Pregnant lady, severe symptomatic MS valvue area <1cm2, pressure gradient >15mmHg ◊ rx ◊ valvulotomy — ??
45. An old man in nursing home with headache neck stiffness fever. All signs of meningoencephalitis. Csf showed sugar 3.5 mmol protein 0.8g/dl lymphos 70% neutros 5% gram negative rods on gram stain, Serum glucose 6mmol. What is the best tx? APMICILLIN + CEFTRIAXONE

↳ E.coli - Klebsiella

Pulsus Alternans

46. Patient with left flank pain with hematuria
A. KUB
B. Ultrasound abdomen/pelvis

< 1.5cm = severe MS

< 1cm = V. severe MS

47. Smoker mucosal gland enlarged
Chronic bronchitis
48. Legionella patient cant take macrolide ◊?
49. Diplopia dyarthria and one more
Basilar artery infarction

- pulsus Bisferiens

50. COPD pt having resp acidosis scenario ..
Ans.Oxygen inhalation 2-3L/m
51. Q... pregnant lady HIV +ve, drug which can prevent /dec tx to disease to baby..
Ans , Zudovidine/or any other??
52. Dialysis patient now developed carpal tunnel features ◊cause ◊ dialysis related amyloidosis
53. Pt having right side burning pain after stroke which lo e involved
Frontal
Temporal
Thalamus

thalamic pain syndrome or parietal lobe → Central ~~pain~~ post stroke pain

- pulsus paradoxis.

54. Patient with features of carpal tunell syndrome + sleepiness ◊ hypothyroidism
55. Diagnostic investigation of idiopathic hemochromatosis
A. Liver biopsy e iron stores ✗ → doesnot differentiate b/w other causes of scc. HFE gene Mutation Hemachrom
56. Man with fever and jaundice ,lfts shows heamolytic pictures diagnosis
Plasmodium faclparum

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56. Man with fever and jaundice ,lfts shows heamolytic pictures diagnosis
Plasmodium faclparum
57. Idiopathic hemochromatosis – high iron low TIBC
58. Patient having loss of vision with macular sparing..cause??
left sided occipital stroke
59. Scenario of conn syndrome
60. A 35 Yr old woman having syncopal attack. Ejection sys murmur n echo showed interventricular septum (thickened) or something. Best tx for her?
1. ICD
2. Beta blockers
61. Soldier returning with 3 day history of fever. Intercellular ameboid like organism seen with blue cytoplasm.
Leishmania
Trypanosomiasis
Falciparum ✗
Babesiosis ✗
62. Left leg pain DVT best diagnostic test
Doppler — Good.
Left leg venograhy — Best.
63. Common cause of SAH
~~Av~~ malformation
Berry aneurysm
Htn

— Jaulan paradoxis.
— Anacrotic pulse
ICD preferred over β-blockers.
normal Approx 1cm.
3.5cm → HOCM
HOCM → surgical septal myomectomy or Alcohol septal Ablation.
macrophages.
?? check
amastigotes

Rx of gram – ve Rods:- Pneumonia
- 3rd generation cephalosporins
- Aminoglycosides (amikacin/ Gentamycin)
- Quinolones
- Carbapenems

~~SAH~~ causes
#1 cause = Head trauma
#2 Aneurysm
#3 AV – Malfor

Hepcidin ↑ → ACD
↓ — Fe Def Anemia

~~Atten~~ gram -ve cocci — Neisseria
Moraxella catarrhalis.

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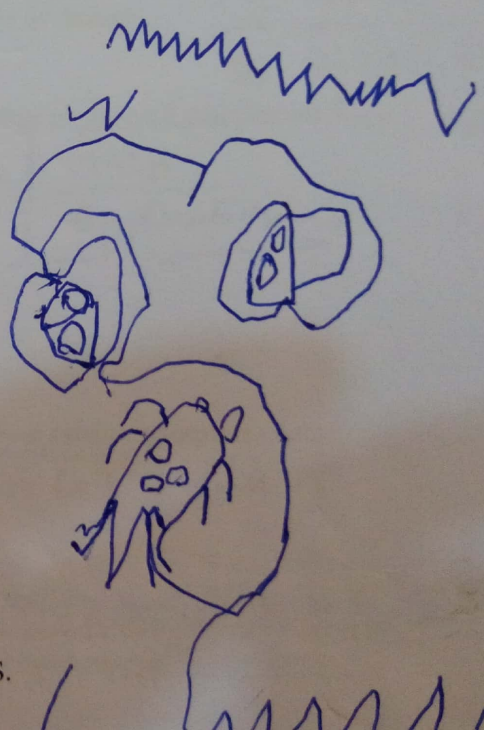
64. Autospy - 3500 gm yellow enlarged liver ◊ Galactosemia
65. Young female died autopsy showed large dilated heart ◊ coxasake virus b
66. Bronchogenic carcinoma case ◊ develops nephrotic syndrome ◊ membranous nephropathy
67. There was a scenario of pt having cough etc with bilateral pulmonary infiltrates on cxr n later developed air fluid level containing cavity in upper lobe. ◊ staphylococcus aureus
68. Operated for Asd with hemorrhages in retina, now feverish ◊ infective endocarditis
69. Profuse diarrhoea
V.cholera?
70. Pt went to his vlg after a long time shortness of breath, wheezing + labs were leucocytosis with neutrophilia
Ans. Ext Allergic alveolitis
71. Q.. medical student, got prick, pt was HBsAg+ve & antiHCV +ve, AntiHIV -ve... his labs show HbsAb.--> previous vaccination
72. Q....CKD pt, renal osteodystrophy?
def of 1, 25 vit D ??
73. bleeding scenario with raised APTT and RAISED BT
ans : was von willibrand disease
74. scenario of fever + bleeding, blast cells and auer rods ◊ AML
75. post Thyroidectomy tingling and numbness.
Ionised calcium ?
76. Short qt interval
Likely cause ◊ Ca 12.4
77. Main lad 50% rca 70% moderately severe as???
Cabg +avr
78. Scenario of HUS
79. pheochromocytoma
24 hour urinary metanephrines should have been chcked first before operating
80. CLL scenario
81. Patient with fever cough sharp intermittent chest pain
A. Costochondritis
B. MI
C. Pulmonary infarction
D. Acute pericarditis
82. Scenario fo HOCM ◊ SAM on echo
83. Girl wd ascending weakness power decreased, severe resp compromise, GBS.
Ans, FEV1/ neg inspiratory pressure / vital capacity??



Scanned by CamScanner

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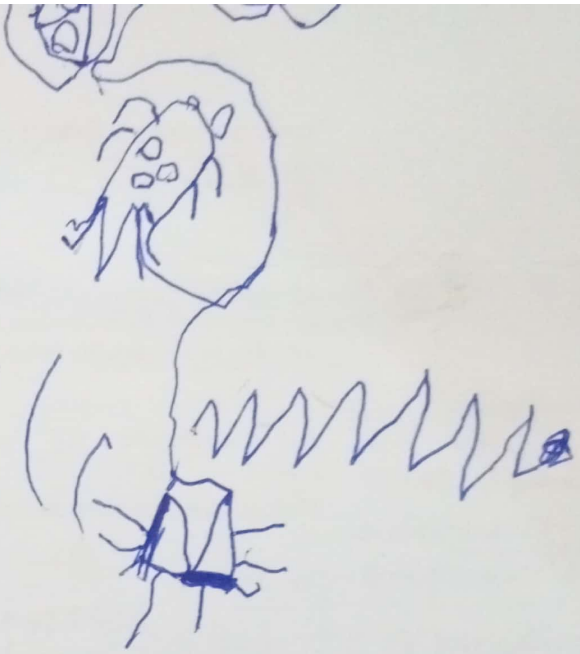
Dr. Iffat Hanif



82. Scenario fo HOCM ◊ SAM on echo
83. Girl wd ascending weakness power decreased, severe resp compromise, GBS.
Ans, FEV1/ neg inspiratory pressure / vital capacity?? — ??
84. pesticide
Ans : pralidoxime
85. wheat pill scenario — ??
86. Hostel mates started to have vomiting after 5 hours staph aureus
87. Differentiating point between Graves disease and toxic multinodular goitre
A. Myopathy
B. Cardiomyopathy
C. Onycholysis
D. Tachycardia E. tremors } ??
88. Fever +r ash ◊ rubeolla
89. NSTEMI scenario rx ◊ IV heparin + beta blocker + aspirin
90. Scenario of cataplexy – sudden loss of muscle tone triggered by emotions.
91. Prgnt lady with low platlets, anemia. Fever. Alt 140 alp raisd.
HELLP
Acute fty liver of pregnacy } → ?? Diffrence b/w Acute fatty liver of preg & HELLP.
Intra hepatic choletasis
92. Nursing home resident + falls + episodic confusion ◊ subdural hematoma
93. How to differentiate type 4renal tubular acidosis from type 2 RTA – ans serum potassium — RTA 4 = ↑ K. RTA 1,2 = ↓ K.
94. Patient on clindamycin developed diarrhea. Rx ◊ vancomycin
95. Lesion of MS will be visualized in ____ on MRI? ◊ white matter
96. Female 4 hr before she was fine now presented with middle cerebral infarct on ct with focal deficit.rx ◊ IV alteplase — <4.5 hours

Rx of diabetes ans é Diarrhea → Lomotil (Diphenoxylate + Atropine).
Imodium (loperamide) —

7 dehydro cholesterol —(4 U light)→ 25 hydroxy vit D (25OHD) ⟶ b25(OH)D.

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97. Patient had all risk factors for atherosclerosis.came with dysnea.workup done showed ef 20 with enlarged heart and global hypokinesia.what investigation ◊ coronary angiography
98. High grad fever 102f,kernig positive pulse 90bpm?
Meningitis
Malaria
Enteric fever

Kernigs → knee.
Brudzinski
↳ flex (Brain) Head → knee - Hip also flex

99. Boy with colonic disease in which APC gene is mutated ◊ Familial adenomatous polpyosis
100. Pyloric stenosis vomiting metabolic anomoly
1. Hypokalemic alkalosis with alkalinuria ✓
2. Hyperkalemic alkalosis with alkalinuria ✗
3. Hyperchloremic alkalosis ✗
4. Hyperchloremic acidosis ✗

Hypokalemic Hypochloremic Met. Alkalosis → Alk urine ??

101. Tall, slim male developed sudden onset of chest pain and dyspnea ◊ pneumothorax
102. middle age female with lateral gaze palsy,headache and diplopia,investigation of choice?
1.mri brain ✓✓
2.csf

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103. young male presented with chorea and abnormal LFTs, rx of choice at this stage of disease ◊ pencillamine for Wilsons.
104. Senario of SIADH
A. urinary NA 8 ✓
B. Urinary K >30
C. Urinary specific gravity 1005
D. Urinary osmolality >100 mosmol/kg

Urinary Na > 20 = Renal loss of Na | SIADH / Hyponatremia.

105. SLE patient developed carcinoma of bladder. Cause ◊ cyclophosphamide
106. Sodium rich food was
Cereals
Can of soup

???

107. 56 years old female Patient with lower back pain,family history of breast cancer,calcium phosphate normal, what is best initial Treatment?????
Start HRT
Bisphosphonate+ calcium
Bisphosphonate only
Calcium + vitamin D

↳ Bisphosphonates vit D & Bisphosphonates (not Ca) ↓ risk of vertebral #

#1 #2
108. CKD patient needs tooth extraction. How to stop bleeding if desmopressin is unavailable ◊ conjugated estrogen ✓
109. Pleuritic chest pain and fever. Heart sounds were distant, Radiology showed enlarged heart silloutte.

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109. Pt wd pleuritic chest pain and fever. Heart sounds were distant, Radiology showed enlarged heart silloutte.
Next test?
A. Echo
B.CT
110. Patient c.o chest pain. Bp 80/40,ECG V tach.r x ◊ cardioversion
111. Pt with fever n pleuritic chest pain. Bronchial breathing in right axilla. Prophylatic treatment must include
Pneumococcus or staph
112. OBESE DM HBA1C 8.5
METFORMIN
113. Gold standard test for diagnosis of acromegaly
Glucose tolerance test – following GH measurement
114. For 20 years unfaithful wife history of depression suicide
Delusional disorder
115. Pt with low sodium 132 k 6.5 ,drug responsible
Amiloride
Loop diuretics
Thiazide
Ace
116. Pt had deafness nd hematuria.
Test to do?
A. Renal Bx.
117. One was that jerky pulse large a wave jvp ejection systolic in left sternl base pan systolic apex.
Pulmonary stenosis. MS. Hocm. Ar. Aortic sclerosis
118. young male had a severe conflict with parents
TOXICOLOGY SCREEN

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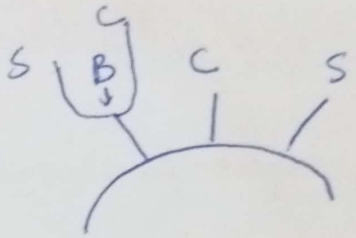

119. Pt with Av dissociation ,BP 110/80,HR 48 Serial ECG. Electrophysiology. Pacemaker. Echo Holter
120. BP IN upper right arm 150/90 and left leg is 80/40 with pan systolic murmur best heard at the back of the chest
1. Coarctation of aorta
2. PDA
121. Abdominal pain + jaundice + dark urine
• Ans Biliary colic
122. One scenario was a man with typical chest pain came to hosp duration 2 hrs. What tests can be done after this 2 hr period that will help in dx. 1. Cardiac enzymes 2. Echo3. ECG4. Trop T
123. Hospitalized old male developed diarhea .c deficile toxin positive.diffuse colonic thickening. What would be seen on histopathology?Pseudomembranous colitis
124. Alcoholic patient develops jaundice, weight loss. Most specific signs to confirm diagnosis ◊ Courvoisier law
125. Patient with features of muscle weakness. Test to reach diagnosis ◊ muscle enzyme test
126. Test that would be normal in Malabsorption syndromes ◊ barium enema
127. Scenario of needle stick injury, HbsAg is positive, anti-HCV, what to do next? Hb core IgM antibody
128. Risk factor for emphysema ?
129. Scenario of CSS syndrome patient who developed CKD. What bone complication is likely to occur ◊ osteitis fibrosa cystica
130. Collapse after laugh day time sleep and vivid dreams....
a) Narcolepsy b) Absence seizure
131. UC Patient presented with jaundice, ERCP shows dilated intrahepatic and extrahepatic ducts with normal ducts in between. Dx ◊ans – Primary sclerosing cholangitis
132. Young female, renal artery stenosis is thought to be cause of HTN. What finding is expected on CTAngiography ? ans – Fibromusuclar dysplasia
133. Patient with A – fib , calculate CHAD2VASC score and tell treatment? Warfarin
134. Male, abdominal pain and lump in right iliac fossa. Diagnostic test ◊ Colonoscopy with biopsy
135. Asthma patient, complain of severe dyspnea first step ◊ PEFR or ABGs
136. Patient complains of red eye, burning sensation, x ray b/l lymphadenopathy, skin rash. Diagnosis ◊ sarcoidosis
137. Fever + arthritis + pleuritis + abdominal pain ◊ familial medeternian fever
138. Patient complains of dyspnea, EF 47% - diagnosis ◊ Systolic dysfunction
139. Patient complain double vision. One week back eye trauma, o/e nasal boil, lateral rectus palsy, 3rd nerve palsy ◊ cavernous sinus thrombosis
140. Muscle weakness scenario. Potassium 2.4 mmol/l- familial periodic paralysis
141. Diagnosis of h pylori – C urea breath test
142. HSV ◊ recurrent genital lesions
143. Offensive diarrhea for 6 weeks ◊ Giardiasis
144. Drug that causes muscle weakness and pain ◊ SImvaStatin
145. k/c rheumatoid arthritis on DMARDs, now presented with abnormal LFTs ◊ methotrexate

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145. k/c rheumatoid arthritis on DMARDs, now presented with abnormal LFTs ◊ methotrexate
146. young lady, ask doctors to tell about medical cause of Fatigue ◊ review her medical records as soon as possible
147. Urinary hesitancy now presented with backache ◊ MRI spine
148. A pregnant lady, has blood pressure 150/90. Which drug can not be given to her ◊ enalpril
149. Diabetic patient develops HTN, and symptoms of intermittent claducation. Drug to be given ◊ ACE Inhibitors or CCB
150. Severe headache,in right side of temple. Ans high dose steroid plus temporal artery biopsy
151. k/c rheumatoid arthritis, now unable to walk, comb hair or rise from chair, o/e plantars are upgoing ◊ inv ◊ MRI cervical spine

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① urea breath test. -non invasive test for H pylori.

H pylori
Urea —urease.→ Ammonia + CO_2.

measured by urea breath test measures exhaled CO_2.

② Rapid urease Test = Invasive.

urease producing organisms = H pylori

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IE — Rifampicin is necessary to penetrate biofilm of prosthetic valve endo

52) Pt.has hemoptysis and cXR is normal..FBC normal.next to do is? (Dnt remember exact senario)..help me in recalling it. Bronchoscopy Ct chest Sputum analysis Mediastinoscopy Clotting profile

53) Hcv positive pt.with ascites and abdominal pain..diagnostic tap showed 75% neutros..pt will benefit from Iv antibiotics Therapeutic tap Transjugular shunt..i hope this was the scenario

54) Patients ACTH levels raised and cortisol raised..low dose dexa dint supress but high fise dexa did suppression..next todo MRI pitutary.

Done

55) pt with h/o fever drenching night sweats n wt loss cxr normal does anyone remember? Brucellosis

56) Tdt positve and negitive etc Burkitt Mucoid fungoides Cll Lymphatic

57) Rabbit bite 1. Rabies immunoglobulin 2. Vaccine 3. IV antibiotic 4. Vaccine + immunoglobulin

58) Scenario on Wilson disease

59) Autoimmune hemolytic anemia with platelet count 60000, what is Dx? Evans syndrome

60) there was schedule of rabies vaccine asked I think 0 3 7 14 28 days

61) Pt.with smoking,htn and sudden onset abdominal pain..dnt remember exact senario..but it was i think Atherosclerotic aortic dissection

62) Pt having history of confusion loss of vibration sense absent ankle and extensor planters diagnostic investigation? B12

63) Diabtic with diarrhea Loperamide?

presubclavian coarctation → Radio radial delay.

64) Pt.with radio radial and radiofemoral delay..cause is Coarctation of aorta before origion of subclavian artery Descending aorta coarctation

65) Renal involvement , immunofluroscence shows igm , C3 deposition 1. Minimal change 2. Diabetic nephropathy 3. SLE 4. Cryoglobin

↑ RSGS → damage to podocytes

66) Patient with right hypochondrial pain of gradual onset,developed jaundice and fever..palpable mass in rt.hypo..dx. Choledochal cyst Biliray atresia Hydatid cyst Hepatic cyst Reidel lobe of liver

67) Pt with ho of rash and low plt investigation of choice

68) Patient has resp infecton n tk clarith for it Rti resolved then develop renal failure Ciclosporin toxicity CmV infection Acute rejection

neurogenic claudication

69) Smoker with 2 yrs gradual onset hx.of pain and stiffness in both legs when he walks for 10 min..his pain relieves wd rest..pulses palpable..dx. Spinal stenosis Peripheral vascular disease Disc prolapse

70) Alport syndrome wala senario kya tha? Family history of renal disorder and common in males? With lense dislocation,hearing loss?

71) smoker who had hemoptysis.and cxr showed left hemidiaphragm raised with left hilar enlargement.next to do Broncho Ct

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xanthoma

72) Pt.with HTN and had yellowish lesions on elbows..do Fasting lipid profile Skin biopsy

73) IE strep viridans , sensitivity to penicillin , but pat is allergic wat antibiotic to use 1. Ceftriaxone , 2. Vanco 3. Genta

74) Two weeks after delivery lady presented with unconciousness and rt sided weakness, o/e she can not move rt half of her body , rt plantar extensor, fundus ok , csf 1200 cells 60%polys what invest u do for diagnosis 1. Ct brain 2. Mrv 3. Mri with contrast 4. Csf analysis → ?? Diagnosis

75) Pt with ho of diarrhoea for last 10 yr now jaundice with pruritis alp increased/ama negative diagnosis? PSC → ASC & UC.
↳ U/S

76) Ho joint deformity with Charcot joint with decrease sensations and reflexes.DM

77) Pt with Graves opthalmoparhy drug of choice? Steroids

familial cause of renal Dx = Polycystic & Alport.

78) female with history of renal disease farher n uncle died of renal disease what to do? usg+?++

79) CRF pt.with 6 months tx of oral iron..now Hb 10.7.. what to do S/c erythropoitin S/c erythro plus iv iron Continue oral iron

80) Upper lobe fibrosis R.A Scleroderma Ankylosing spondylits

C3 ⊕

2g { G — M — Membranous
A — A — IgA Nephropathy
M — F — FSGS.

X

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for CNS / ocular manifestations → cyclophosphamide, cyclosporin, infliximab.

81) Bechet disease off treatment 2 months , CNS symptoms , csf pic was normal sugar n proteins , 14 cells with 80% lymphos 1. Dexa 2. Acyclovir 3. Immunosuppressants 4. Rituximab

82) Steroid induced osteoporosis prophylaxis..... bhisphosphonates — alendronate, risedronate

83) Scenario on dermatomyositis

84) Fever with low TLC and relative bradycardia. Dx? Typhoid

85) Elderly lady presented with weakness in her lower limbs, difficulty to walk, she adds progressive bending of her spine over few years , brisk reflexes in lower limbs, planters extensors Wat investigation u will do 1. Syringlomylia 2. Cervical myelopathy

Mixed → Anti RNP.
Anti centromere = CREST.
SSA SSB Sjogren
Ro / La
Anti SCl 70 — Sys. Sclerosis

86) There was a senario of nephropathy in 15 yrs old boy..any one remembers? Minimal change Fsgs Membranousv

87) Chronic Hcv tx. Sofosbuvir plus daclatasvir IFN only IFN plus ribavirin

88) Pt.with dysphagia,blyish discoloration of fingers,telangiectasia and tightening of skin..test to do..dnt remember exctly it was a MCTD or S.S senario. Anticentromere Anti RNP Anti Ro Anti La (Crest Syndrome Anti Centromere)

89) Pt.after fever has low platelets and prolong APTt 76 and PT 35..cause DIC Hemophilia VWB disease

90) There was a baba who was on list for spinal anesthesia in uro..came to ER in retention..drug responsible was Ipratropium? — ??

91) Pt with sperm count of 1000, next investigation? — Normal sperm count = 15–200 million/ml

92) Pt.wth CCF..BAL done..it will show hemosiderin laden macrophages. Cilited epithelial cells

93) Pt.developed deranged RFts after ATT..dx. AIN ~~ATN~~ → Rifampicin.

94) Pt.with butterfly rash and arthralgias and renal involvement..suspected SLE..best test for dx. Renal biopsy Anti ds DNA Complement levels

95) Pt.with hemoptysis and purulent sputum for 3 months..cxr upper lobe consolidation Chronic bronchitis Pulm tb Copd Bronchiectasis Ca bronchus

Purulent sputum x 3 months. 2°

96) Pt.with 9 lac platelets..what to be done Exclude myelodysplasia Exclude other causes of thrombocystosis Jack 2 mutation BCR ABL → philadelphia ← CML ALL

Polycythemia

97) 3 wks after pregnancy,a girl developed one sided weakness..fundus normal..what to do.. MrV MRI with contrast Ct scanbrain → Diagnosis — ??

98) Young boy with recurrent jaundice with coca cola colured urine..dx. G6pd → Intravascular Hemolysis

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PNH Malaria

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100) Young boy with recurrent pain in finger p.smear shows Howeljowlly bodies with target cells..dx.is Heriditory spherocytosis Sickel cell

101) Lymphoma pt.with herpes zoster of S1 n S2.. took acyclovir for 3 days..no improvmnt..what to do Iv acyclovir plus steroides Acyclo plus lamivudine plus amantadine

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I/V Foscarnet

102) Pt.with lymphoma and cutanoues lesion having CD4 T cells,tdt negative and has circumferenitial appearance...i guess..dnt remember exactly..Dx. Mucosis fungoides Lymphblastic lymphoma Burkitts lymphoma HIV

103) senario of snakebite 12 hrs ago..now drooping eyelids,dysphagia..best tx.to save his life Antivenom

Adrenaline Mechanical Vent, ~~Decrease Analgesics~~ Empower CPSP with agenuine passing Criteria

104) There was a senario of aortic stenosis and its associtaion with..i guess Angiodysplasia? → Heydes Syndrome

105) precocious puberty senario..what to give Testosterone Estrogen Estrogen plus progesterone — GnRH Analogs — Leuprolide + progesterone.

106) Pt.with severe diarrhea,dehydrated..best fluid Normal saline Ringer lactate

Raynauds → Amlodipine — Nifedipine (CCB — 1st line).

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VT → VoT for Ami

for pulseless VT. 4

107) Pt.with vent tachy of 180/min.bp 90/60.tx.. Amiodarone 300mg Lidocaine synchronised DC

108) Pt.with on off hx.of dry cough that makes her wakeup at night occasionally,has occasional wheez..dx. Br.asthma

109) Female with family hx.of thrombosis..test to do Factor 11 Protein c,s and antithrombin 3 levels

most common hereditary thrombophilia = Factor V leidin Def.

110) Pt.s RBC have low lactate..deficient enzyme is LDH Pyruvate Hexokinase G6pd

111) Pt.with platelets of 45000.no epistacis and menorrhagia..next step Bone marrow Do plats every fortnightly Prednisone ?

112) Diabetic for 10 yrs with poor compliance came after 4 months for checkup..has marked glycusuria..test Hba1c Rbs Fructosamine

3 Months

113) Pt.on tx for heartfailure and taking simvastatin has bodyaches and muscle pain..do Cpk LFTs Musclebiopsy

114) A boy with short 4th metacarpel Pseudohypoparthyroid

115) Pt.with severe fapciparum malaria..pregnant..tx. Chloroquine Quinine Primaquine → Artemether lumafantrine is Best if given in option otherwise tick Quinine

Resistance is issue

116) Best test for pagets is ALP → markedly

117) Teacher with hearing loss gradually,ALP raised.. Pagets M.M → deafness, → Pagets.

118) One senario was carcinoid where patient had episodic flushing and diarrhea and we had to do HIAA as test..and other similar senario was of pheochromo.right?

119) Young pt.whose RFts deteriorated after lisinopril.baseline RFts were normal..renal artery stenosis?

120) Pt wid head injury n hyponat . Siadh,Dilutional hyponat

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121) Insecticide poisoning senario..ans Pralidoxime

High High

122) Pt.has polyuria with plasma osmolality 300,urine 304,after water deprivation urine is 330 and after desmopressin it is 327..cause is Psychogenic Central DI Nephrogenic DI

correct

→ nearest

123) 45 yrs old with 30 years hx of smoking developed DVT. hb 16.plats and wbc normal.cause of DVT is Primary PRV Secondary polycythemia

124) Young boy wth polyarthralgia,abdominal rash..HSP?

125) A senario of infective endo probably.(Fever and pata nahi kiya).where investigation to be done was TEE

126) Pt.with hemoptysis and renal involvment..test P anca? → churgg straus → P-ANCA
wegeners → C-ANCA
Good pasture → Microscopic Polyangiitis → PANCA

127) There was a senario of pancytopenia with no megaly.. Aplastic?

128) Pt.with HTN and D.M with proteins in urine + ,best drug Lisinopril Thiazide

129) Patient with ascites and bla bla.(kindly complete if anyone rememebers)dx.was SBP Liver abcess

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124) Young boy wth polyarthralgia,abdominal rash..HSP?

125) A senario of infective endo probably.(Fever and pata nahi kiya).where investigation to be done was TEE

126) Pt.with hemoptysis and renal involvment..test P anca?

127) There was a senario of pancytopenia with no megaly.. Aplastic?

128) Pt.with HTN and D.M with proteins in urine + ,best drug Lisinopril Thiazide

129) Patient with ascites and bla bla.(kindly complete if anyone rememebers)dx.was SBP Liver abcess

130) Pt.withankle edema and was taking many drugs..echo n cxr normal..drug causing edema was Amlodipine right?

131) Pt.of known ca.lung came wd unconsciousness..was given i.v saline..still drowsy, Na 128..what to give.. Steroides n normals saline
Fluid restriction

132) Senario of lymphoma where pt.got symptoms of tumor lysis syndrome..prevention cud be done wd Allopurinol?

133) 50 yrs lady with abdominal pain.constipation and bone aches,acute pancreatitis cause is Hypercalcemia Gallstones

134) Pregnant lady in 31 st week gestation had deranged LFTs..and RFts as well i guess..what was that? Acute fatty liver of prgnancy Hepatitis

135) A person got bitten by Rabbit,what step to take Active immunisation against rabbies Passive immunisation against rabbies Both active and passive immunisation Immunisation against tetanus Observe

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Pt with TLC 1900,platelet 6000,viral haemragic pic YELLOW PICTURE
Diabetic patient with Rhinosinu Mucor mycosis. Full Hx forgot.
Best treatment
1. IV amphotericin B
2. IV Amphotericin B with debridement
3. Fluconazole
Forgot others
Obese lady with recurrent UTI what will you do next
1. Urine R/E
2. FBS
3. HBA1C
4. USG abdomen
Forgot other one But CT and urine CS were not there
Painless loss of vision
Disc pale with blood less arterioles → Retinal A obstruction.
Diabetes with malaise,sweating and productive cough and chest pain for 2 weeks.
O/E upper lobe consolidation
Treatment
1. Only Isoniazid
2. Antiboitics
3. INH,Ethambutol and Rifampin 4. Steroids (i think)
Patient with AIDS with CD4 count 50. (Full HX was given but I forgot).
Most common organism causing meningitis
1. Cryptococcal
2. CMV
3. Toxoplasmosis
4. Staph Areus
Few drops of blood at the end of micturition.wat Ix is best
Cystoscopy
IVU
Renal biopsy
Young boy with Cough,fever and recurrent hematuria.
Forgot full Hx.
Dianosis
1. CSS
2. Alport — deafness + lens dislocation
3. WG
Lady with SOB and on OCPs. Forgot full HX. Tachypnic and tachaycardic. — PE.

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- CPSP has the worst passing criteria when compared to other

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Dianosis
1. CSS
2. Alport — deafness + lens dislocation
3. WG
Lady with SOB and on OCPs. Forgot full HX. Tachypnic and tachaycardic. — PE.
Most common finding in ECG.
full HX and full labs but i think it was PE.
99.sexually active young male acute pain right knee joint.had same episode last year.TLC 14000.Joint space normal..joint aspirate cell count 50,000. — Gonococcus, ~~Reiters~~ Reactive
100.50yr lady with acute knee joint pain,uric acid 6.8..TLC 20,000 joint aspirate cell count 30,000.
Gout,gonnococcal,non gonnococcal,reaticve.
Patient with fever and headache and malaise.
CBC hows HB 10,TLC 12000 and platelets 150000. His APTT was 50. Forgot full HX.
Diagnosis
1. ITP
2. TTP
3. HUS 4. DIC
Full HX of isolated pulmonary nodule 1.5 cm in size and popcorn like appearance. — Benign
Most appropriate step
1. Compare with previous Xray
2. Urgent Bronchoscopy
3. Biopsy — for Malignant nodules.

→ size > 3 cm = to be considered Malignant until proven otherwise.

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4. CT chest
Patient with CLL on remission by treatment (given in Hx) presented with signs and symptoms of anemia (given in Hx).
US shows massive Splenomegaly.
HB 8(some value like this), Low platelets and WBS 50000(value like this),
P- smear show Spherocytes and polychromsia.
Retic was raised . MCV was also raised(values given in Hx).
Cause of anemia
1. HS 2. Autoimmune Hemolytic anemia
3. Hypersplenism
Patient with hearing deafness,lenticular (some problem), lens dislocation and renal dysfunction. Forgot full HX and options but i think it was Alport
old male patient with jaundice,fever and right HC pain.
US or CT abdomen showing some intra Hepatic abnormalities (I forgot full HX).
But i think it was PSC
Hyponatremia in patient with head trauma (closed trauma was mentioned).
Na 131 (some value like this).
Investigation of choice
1. Serum and urinary Osmolality
2. Xray pituitary (Not MRI)
3. Urinary Na 4. Serum Osmolality
Patinet with Chest pain and ECG shows ST segment depression.
Treatment
1. LMW heparin
2. Unfractionated Heparin
Whats not common in waldenstorm Macroglobineia
Sohail Khan Many of the mcqs posted here are from imm q bank,means even imm mcqs are worth value in part 2
intermediate module page
Patient with full HX(I forgot) with dysphagia and barium shows birds beak

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Hyponatremia in patient with head trauma (closed trauma was mentioned).
Na 131 (some value like this).
Investigation of choice
1. Serum and urinary Osmolality ✓
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intermediate module page
Patient with full HX(I forgot) with dysphagia and barium shows birds beak appearance.
Next most appropriate investigation Achalasia – Manometry
1. Manometry ✓
2. 24 hour PH
3. Motility studies
4. Endoscopy
Patient with three days hx of high fever with rigors and took Amodiquine but no response. Was in coma.
[illegible] supple. No rashes.
I forgot others.
Treatment
1. IV quinine ✓→ check
2. IV Ceftriaxone 3. IV benzyle penicillin
4. IV antifungal
Lady after tooth extraction with bleeding. BT 12 minutes.
APTT raised. Forgot others
Diagnosis
1. Van Willibrand's ✓✓
2. Hemophilia
3. DIC
Player in sports (forgot whether foot ball etc) became unconcious. His friend tells he was having DM.
Forgot full HX.
Diagnosis
1. Hyperglycemia
2. Hypoglycemia ✓
Forgot other options
with all labs normal including Alkaline phosphatase,But Calcium was low.

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DEXA scan showed Decreased bone density – osteoporosis
Treatment
1. Bisphosphonate # 1 for osteoporosis 2° steroids
2. Calclium and Vit D supplements # 1 for osteoporosis
3. Calcium supplements

↓ verteloral #
# ~~1 Bisphosphonate~~
# 1 Vitamin D
# 2 Bisphosphonate
Ca = X, ↑ Coronary events

16 years young boy with ataxia,limbs strange movements(Names given but i forgot) with no family hx of such disorder. Other features were there but i forgot.
Diagnosis
1. Friedrich's ataxia
heriditry spastic paraplegia

Patient with severe retrosternal chest pain and choking sensation for one hour. BP was 100/70. Tachaycardic.
ECG showed ST segment depression.
Diagnosis
1. Aortic rupture
2. MI ✓— ? Check
3. Acute pericarditis

Young school teacher lady with unconscious and O/E Upgoing planters,dilated pupils with sluggish response to light.
Tachaycardia was not mentioned.
Rest was straight forward TCA

Patient with arthritis of right knee and left ankle .
O/E effusion of right knee.
Aspirated and show WBCs 100 and crystals which are positive for Bifreingent.
Diagnosis
1. Gout
2. Hemochromatosis
3. Reactive arthritis

pseudogout-knee = Most commonly affected.
Causes of pseudogout = Age, trauma, Hemochromatosis, Hyperparathyroidism

Normal C-Peptide:-
[0.8 – 4 ng/ml
[0.27 – 1.33 nmol/L

Patient with arthritis and malaise etc . Was on trip to US (some northern areas was mentioned). On further questioning he recalles of some rash with central clearing. — E. Migrans
This was straight forward Lyme disease.

Patient with anemia and Splenomegaly. HB low. Forgot full HX.
Diagnosis
1. HS
2. Thalassemia

Mg = Intracellular cation – More than 95% is Intracellular
Mg regulated PTH →
Mg & Ca = Friends -
– Normal Mg = [1.8 – 3 mg/dL
[0.75 – 1.25

Msqs ,, February 2016 ,,
Superior venacavl obstruction ,, Rx radiotherapy , steroids ,
Lyme disesae caused byspirochete , Borreliq Burgdorferi ,
Pheochromcytoma , during operation control b.p with nitroprusside ,, — ??
Yellow nail two msqs ,, — ??.
Pregnancy safe drug cabazipine

Scanned by CamScanner

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Yeaow nail two msqs ,, — ??.
Hemocystinuria ,, DVT , Pregnancy safe drug cabazipine me
Most common factor deficiency , factor 5 , Leiden Def
High saag low protein , portal vein thrombosis
Trmor disappear in sleep , Parkinson
H, pylori , gastric carcinoma ,
Roofer on x ray plaque , asbestose Gbs ,, ncs , GF DMR.
Pain in malignancy , morphine
Pruritis with raise alk po4 ,, antimitochond antibody — PBC.
Obese female with rhc tenderness , cholecyst itis.
Vertigo , increase blood pressure , old age , cause is diuretic
February 2016 msqs .. — Macrolids ne inhibitors
Theophyline plus erythromycin ... Arrhythmias ,,
MDS in bone marrow ,,, ring sidroblasts
Type1 DM ,,, drug acei
Rash plus arth ,,, gonococcemia
Ischaemic heart disease with AF now with deranged tfts cause ,,, amiodarone
Resistant tb , att for 18 months or 2 yrs.
Thin vermis cause ,, alcohol ??

Hyperparathyroidism

Mg = Intracellular cation — More than 95% is intracellular
Mg regulated PTH →
Mg & Ca = Friends -
— Normal Mg = [1.8-3 mg/dL, 0.75-1.25 mmol/L]

Phenytoin
Phenobarb.

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HHS , 4 litre n,saline given still sodium 160 ,, give 0.5 saline
Na , 118 , give 1.8 % n,saline
Alpha one antitrypsine deficiency ,, type of emphysema ,,, panacinar
Tinea corpora skin , treatment is ketocona Hep B prick in non immune ,,
give immunoglobulin plus vaccine
4th yr student , now restless cause is amphetamine
young lady presented with acute ischemic stroke.She is febrile,clubbed and has palpable spleen.Echo confirms small vegetations over mitral valves.Ct brain shows large ischemic stroke.How will you manage her stroke.
1.Start Heparin
2.Thrombolyse
3.Aspirin
4.Aspirin plus heparin 5.Do nothing for stroke
The differential diagnosis of an isolated unconjugated (indirect) hyperbilirubinemia is limited. In a patient with isolated unconjugated hyperbilirubinemia, which of these historic findings would be unlikely?
A. Calcium bilirubinate gallstones
B. Cryoglobulinemia C. History of gout
D. Spherocytosis
E. Recurrent long-bone pain crises
Obese man with sleep apnea and severe respiratory distress and hypercapnea next step?
A. Endotracheal intubation
B. Positive mechanical ventilation at peep 10
C. Oxygen 100%
D. Inhaler B2 agonist
Patient with Tuberculuos pericarditis. Select best answer
1. INH,Rifampin,Ethambutol,PZ
2. INH,Rifampin,Ethambutol
3. INH,Rifampin,PZ
4. INH,Rifampin
A 60 year old woman presents with generalized edema, skin ulceration and hypertension. Urine examination shows subnephrotic proteinuria (<2gm) and microscopic hematuria. Serum complement levels are decreased and she is positive for anti-hepatitis C antibodies. The likely diagnosis is :
A. PSGN

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Obese man with sleep apnea and severe respiratory distress and hypercapnea
next step?
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3. INH,Rifampin,PZ
4. INH,Rifampin
A 60 year old woman presents with generalized edema, skin ulceration and hypertension. Urine examination shows subnephrotic proteinuria (<2gm) and microscopic hematuria. Serum complement levels are decreased and she is positive for anti-hepatitis C antibodies. The likely diagnosis is :
A. PSGN
B. Essential mixed cryoglobulinemia
C. Membrano proliferative glomerulonephritis D. Focal segmental glomerulosclerosis
Apreviously healthy 26-year-old man presents with a 3-week history of abdominal pain and arthralgias. On physical examination, hypertension and palpable purpura of the lower extremities are found. Urinalysis shows hematuria. What is the most likely diagnosis?
a. Henoch-Schönlein purpura b. Cryoglobulinemia, c. Hypocomplementemic vasculitis, d. Rheumatoid vasculitis e. Systemic lupus erythematosus
Primary hyperparathyroidism may occur in association with the following conditions:
1) Chronic renal failure, 2) Vitamin D deficiency, 3) Gastrinoma, 4) Autoimmune polyendocrine syndrome 5) Sjogren's syndrome
MRCP pastest.. Mcq s
Patient presents with Malaria Infection develops rash at the angle of mouth, related complication he can develop
1. Black Water Fever, 2. Cerebral Malaria, 3. Meningiti, 4. Myocarditi, 5. P.gangrenosum
Commonest bug to cause sepsis in asplenic patients...
1. N.meningitidis, 2. Stept pneumoniae, 3. H influenzae type B, 4. P.falciparum

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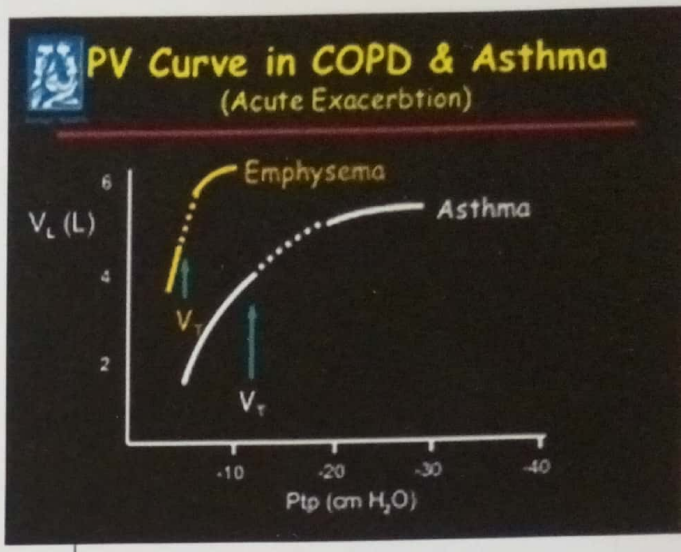
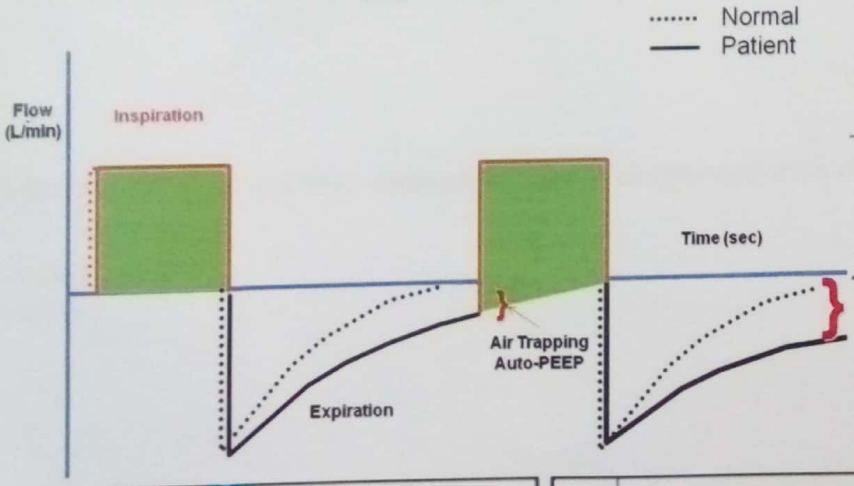
Initial Ventilator Settings

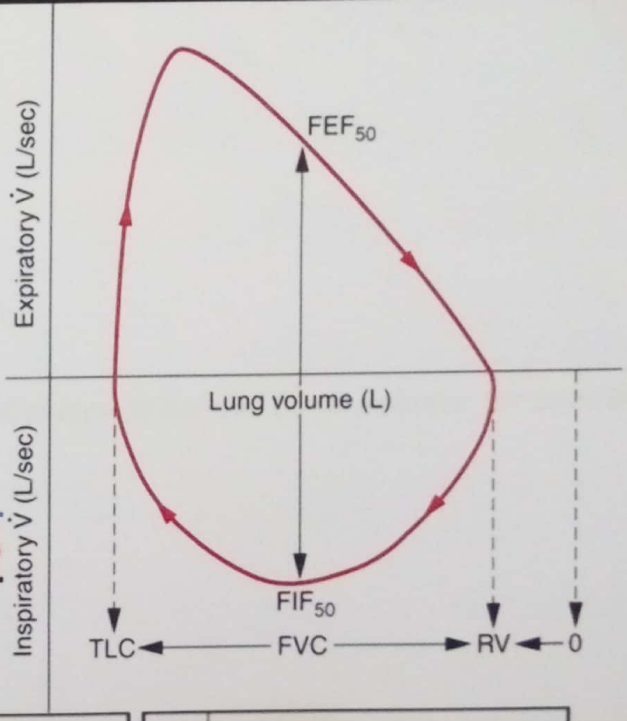
	Tidal Volume	RR	I:E Ratio	PEEP	FiO_2
Normal lungs	8 mL/kg	10–12	1:2	4	1.0
Asthma/COPD	6 mL/kg	5–8	1:4	4	1.0
ARDS	6 mL/kg	10–12	1:2	4–15	1.0
Hypovolemia	6 mL/kg	10–12	1:2	0–4	1.0

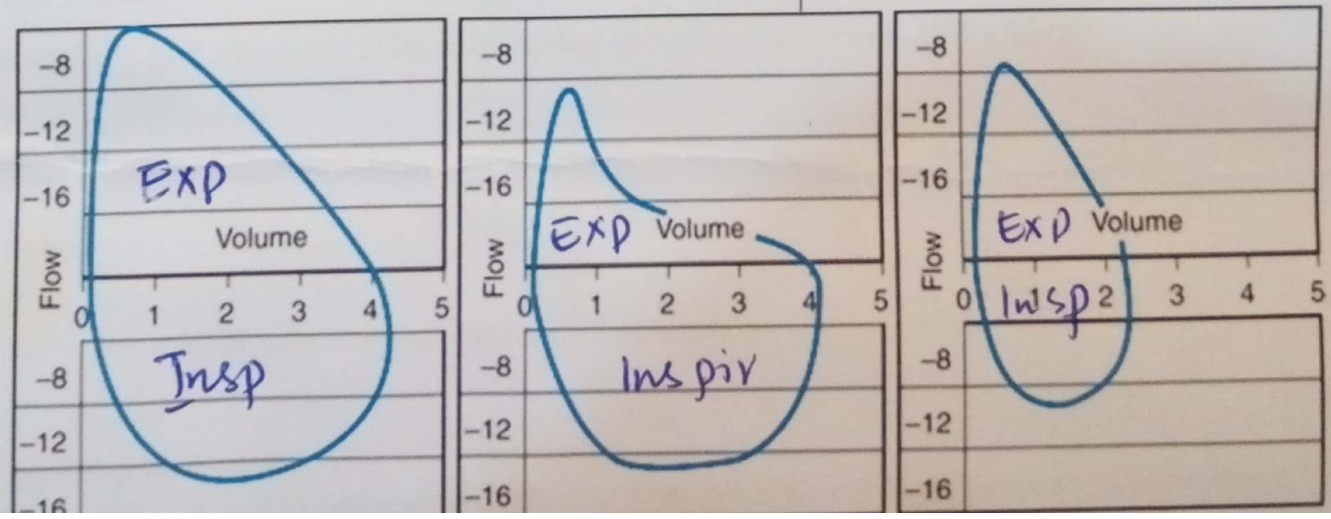
Abbreviations: ARDS, acute respiratory distress syndrome; COPD, chronic obstructive pulmonary disease; I:E, inspiratory to expiratory; PEEP, positive end-expiratory pressure; RR, respiratory rate.



Air Trapping







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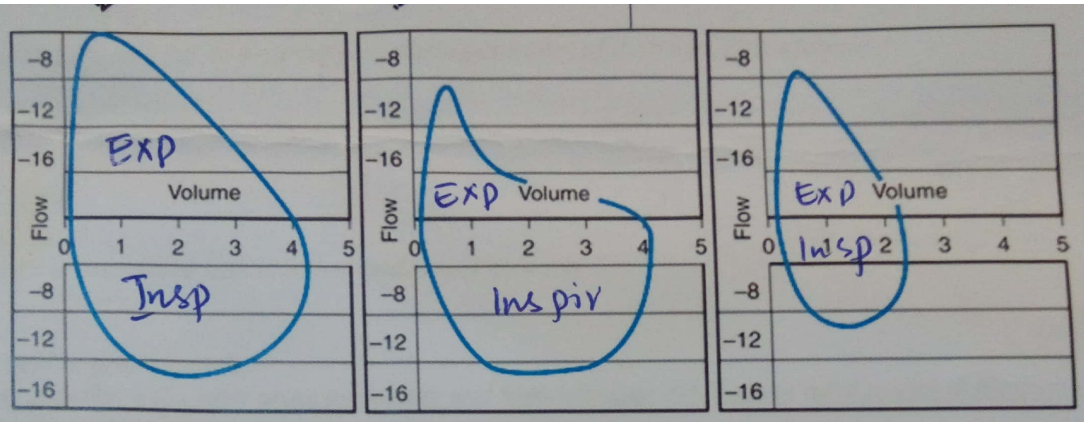
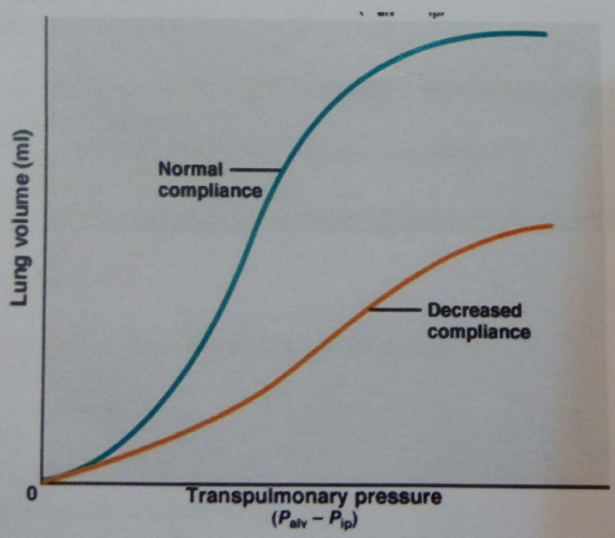
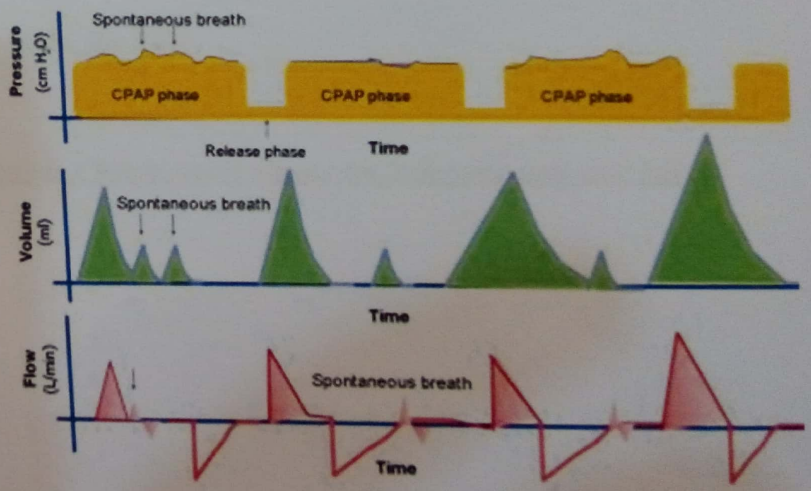




APRV



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Dr Ibrahim
Fcps medicine part 2 mcqs

August 2016 MCQ....

In severe asthma, ventilatory settings not recommended is:

1.increase in minute ventilation
2.decrease tidal volume
3.increase in resp rate
4.prolong expiratory flow rate
5.Shorten inspiratory flow rate

Patient with Left hemiparesis and right Ptosis. Diagnosis
1. Vertebal artery stroke
2. PICA stroke
3. AICA stroke
4. PACA stroke
5. Basilar Artery

Patient who is known coronary artery disease patient is diagnosed with diabetes. What will be the choice for controlling his diabetes?
Short acting insulin
Long acting insulin
Sulfonylurea
Biaguinide

Patient with Right knee joint and left Ankle joint pain during episodes of diarrhea. O/E afebrile
Diagnosis
1. UC
2. Crohn's
3. RA
4. Whipple
5. Reactive Arthritis
Note: Reactive Arthritis is associated with diarrhea and sexual contacts

High dose ascarbic acid to prevent cold..
(note: with high dose ascarbic acid, high urine osmolatity and high/alkaline pH leads to false negative dipstick results of glucose at [illegible] levels)
1.false urine bilirubin
2.false urine glucose.
3.high urine gravity

Patient with gout on NSAIDS presented with severe pain left ankle. His RFTs

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Patient with Right knee joint and left Ankle joint pain during episodes of diarrhea. O/E afebrile

Diagnosis

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(note: with high dose ascarbic acid, high urine osmolatity and high/alkaline pH leads to false negative dipstick results of glucose at [redacted] levels)

1:false urine bilirubin

2.false urine glucose.

3.high urine gravity

Patient with gout on NSAIDS presented with severe pain left ankle. His RFTs abnormal. Treatment

1. Allopurinol (Not suitable for acute attack)

2. Colchicine

3. Steroids (for acute gout treatment is oral nsaids or oral steroids. Cholchicine is alternative (reference upto date 2018)

4. NSAIDS

Forgot other one

IE prophylaxis is indicated in which scenario

1. Primum ASD

2. Secundum ASD

3. MVP

4. HOCM

5. After Surgical Closure of VSD

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50 years old patient worker in Felt Hat factory (textile) presented with some polyneuropathy and vibration and position sense were lost. Which toxin is most likely

1. Lead

2. Mercury(Mercury attacks the central nervous system, and its vapor is readily absorbed in the brain)

3. Organophosphate

4. Magnesium

years girl from Afghanistan with repeated blood transfusions in the past. O/E Hepatosplenomegaly.
Labs : HB 5.6, normochromic normocytic anaemia.

Diagnosis

1. HS

2. Thalassemia major

3. Thalassemia intermedia (thalassemia causes microcytic anemia)

4. Thalassemia minor

Clinical findings n associated with waldenstorm (IgM positive) macroglbulinemia

a)Hyperviscosity

b)Hepatosplenomegaly

c)Lymphadenopathy

: features of macroglobulinemia include: weakness - 66%, Anorexia - 25%, Peripheral neuropathy - 24%, Weight loss - 17%, Fever - 15%, Raynaud phenomenon is due to cryoglobulinemia. Infiltration of the central nervous system by the malignant clone can cause a syndrome of confusion, memory loss, disorientation, and motor abnormalities called the Bing-Neel syndrome. Symptoms due to hyperviscosity syndrome, which can be life threatening, include Bleeding, Dizziness, Headache, Blurry vision, Hearing or visual problems.
Hepatomegaly - 20%, Splenomegaly - 19%, Lymphadenopathy - 15%, Purpura - 9%, Hemorrhagic manifestations - 7%, Papilledema

Patient with thyroid crises.

Best treatment

1. Beta blockers and Prophylthiouracil

2. Beta blockers and Carbimazole and steroids(note: carbimazole is not preferred in thyroid storm)

3. Beta blockers and porphylthoiuracil and Steroids

4. Beta blockers and steroids Forgot other one

Patient on HAART presented with renal Colic. XRay KUB showed radiolucent shadow. Which stone composition is there

*1. Ca oxalate,**[C3T= Radioopaque]***

2. Ca phosphate

3. Cystine (sulphur)

4. Triple phosphate

5. Uric Acid [LUX: Lucent = Uric acid and Xanthine]

(note: protease inhibitor like indinair cause radio lucent stones)

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Fever - 15%, Raynaud phenomenon is due to cryoglobulinemia. Infiltration of the central nervous system by the malignant clone can cause a syndrome of confusion, memory loss, disorientation, and motor abnormalities called the Bing-Neel syndrome. Symptoms due to hyperviscosity syndrome, which can be life threatening, include Bleeding, Dizziness, Headache, Blurry vision, Hearing or visual problems.
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(note: protease inhibitor like indinair cause radio lucent stones)

Regarding IV fluids.
1.hypertonic saline
2.normal saline
3.half saline.
4.dextrose

A.Head injury patient.sodium is 118. Give hypertonic saline

B.HONK.sodium is 155.give half saline

(note: Sodium concentration of common fluids (per liter): normal saline (0.9%) - 154 mEq/L; lactated Ringer solution - 130 mEq/L; half-normal saline (0.45%) - 77 mEq/L; dextrose 5% in water - 0 mEq/L; enteral water - 0 mEq/L*)*

Pt with gastric surgery for peptic ulcer now present with weakness low body, which is cause due

1.hypoglycemia

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2.hyperglysemia
I think it was about dumping syndrome
(note: **Intrinsic factor** (IF), also known as **gastric intrinsic factor**(GIF), is **produced** by the parietal cells of the **stomach**. It is necessary for the absorption of vitamin B12 later on in the ileum of the small intestine. Loss of IF after gastric surgery leads to b 12 deficiency and peripheral neuropathy

Diabetic patient with Ptosis. O/E Pupils normal with normal response to light.
1. Weber
2. Partial 3rd nerve palsy

A young lady with type 1diabetes for ten years.On enalapril.well control diabetes.But persistent microalbuminuria..current urine albumin is 150mg.she came to you for opinion regarding pregnancy.
1.Enalapril is safe in 1st trimester.(Evidence of whether ACEIs cause problems during the first trimester of pregnancy is reassuring. There is evidence that they cause severe renal (oligohydramnios) and other problems during the second and third trimesters, however.*)*
2.Enalapril should be replaced with Aliskiren (direct renin inhibitors)
3.It will have no effect on her disease condition
4.It will hasten the progression of her disease
5.It will get worse but will reverse after pregnancy

a young man with history of joint swelling aspirate count is 50000
Gonococcal arthritis(eg of septic arthritis with wbc 50000-1 lac. This is young male)
non gonococcal
uric acid (inflammatory arthritis RA and gout WBC 2000-75000. Gout common age is 40-50s)
osteoarthritis (non inflammatory arthritis ... wbc less than 2000)
septic arthritis (wbc > 1 lac)

Table 3. Examination Of Synovial Fluid.

	Normal	Noninflammatory	Inflammatory	Septic
Clarity	Transparent	Transparent	Cloudy	Cloudy
Color	Clear	Yellow	Yellow	Yellow
WBC/mL	<200	<200-2000	200-50,000	>50,000
PMNs (%)	<25%	<25%	>50%	>50%
Culture	Negative	Negative	Negative	>50% positive
Crystals	None	None	Multiple or none	None
Associated conditions	—	Osteoarthritis, trauma	Gout, pseudogout, spondyloarthropathies, rheumatoid arthritis, Lyme disease, systemic lupus erythematosus	Nongonococcal or gonococcal septic arthritis

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septic arthritis (wbc > 1 lac)

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	Normal	Noninflammatory	Inflammatory	Septic
Clarity	Transparent	Transparent	Cloudy	Cloudy
Color	Clear	Yellow	Yellow	Yellow
WBC/mL	<200	<200-2000	200-50,000	>50,000
PMNs (%)	<25%	<25%	>50%	>50%
Culture	Negative	Negative	Negative	>50% positive
Crystals	None	None	Multiple or none	None
Associated conditions	—	Osteoarthritis, trauma	Gout, pseudogout, spondyloarthropathies, rheumatoid arthritis, Lyme disease, systemic lupus erythematosus	Nongonococcal or gonococcal septic arthritis

betic lady who had forearm abscess... they asked about empirical treatment

a)cloxacillin
b)cloxacillin and gentamicin
c)amoxicillin

Dr. Nasreen
Dr. Hathim

A lady operated for some esophagus pathology~~(or smthing else wrong)~~ was on total parenteral nutrition.She develops aches and pains in lower half of body and both legs..way is the reason
hypokalemia
hypocalcemia
hypoglycemia.

ICU / GIT

Young lady was donating blood and she says that she got HB vaccination two years back.
What finding will be there in her labs
1. HBsAg + and HBc antibodies +
2. HBsAg + and HBc antibodies-
3. HBsAg - and HBc antibodies +
4. HBsAg - ,HBc antibodies- and HBs Antibodies- 5. HBsAg -, HBc antibodies

Anti Hbs ⊕ with Anti Hbc ⊕ = past
Anti Hbs ⊕ without Anti Hbc = vaccine.

HBs Ag ⊕ → Current infection
HBs Ag ⊕ ⊖ ; Anti Hbc ⊕ ; Anti Hbs ⊕ or ⊖ → Past infection
HBs Ag ⊖ ; Anti Hbc ⊖ & Anti Hbs (must ⊕) → vaccination.

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Best Initial & Best Invest for Aortic Dissection. 4

- and HBs antibodies +
Patient with immunomodulators for RA present with disturbing dry cough and SOB. (Forgot full HX).
CXR show B/L symmetrical shadows.
I think it was PCP
Patient with full HX(I forgot) with chest pain that was excruciating in nature. BP was sky high(given in some 200/110). Hx was like Aortic rupture.
Most appropriate investigation.
1. CXR
2. MRI thorax
Forgot others but answer in these two

Aortic dissection pain is Anterior chest ~~pain~~ or b/w scapule. ↓ descending Aorta. (ascending aorta.)

Investigation of choice for Acute ~~chest~~ aortic dissection is CT Chest + Abd.

For Chronic Aortic Dissection → Investigation of choice = MRI.

Labour Patient with CNS symptoms.fever,significant weight loss. Neck stiffness was there. No papilledema.
Hx was of 2 weeks. No chest symptoms.
Forgot full HX.
CXR was normal.
CSF: Cells 100
Lymphocytes 80%, Sugar 40, Protiens 60, RBS was not given, ESR was raised i think 45 or something
Diagnosis ... TB

A diabetic, admitted with acute MI.He was on a sulfonylurea..well control.HBA1c is 6.8 i think.Creatinine is 4.5.Now what should his diabetes be managed

Strict glycemic control during acute MI Improves outcome

Diabetic & MI & Cr = 4.5.

1.continue with the same sulfonylurea
2.insulin plus glucose
3.pioglitazone
4.metformin.

CMDT – 484.

Bp 70/50.pulse 100.cvp 2cm water.lactate 30 .(9-16 normal)cardiac output 1.9

Cardiac Index (2.2 L/min/m²) = Cardiac Shock.

Cardiac Index = Cardiac output / BSA.

Septic shock
hypovolumic shock → low CI & low CVP (Lt Atrial Prs)
cardiogenic shock → low CI & High CVP (Lt atrial prs)

Normal cardiac index = 2.5–4 L/min/m²

A lady diabetic, on regular insulin and NPH, with good control of diabetes.She is strictly adherent to dietary advice and exercise.but her early morning sugar remains high.blood sugar level chart was given.At 2 pm 90.at 8 pm ?115.dt 8am 215.What strategy you will tell her.

— Dawn phenomene.

Dawn phenomene.

1.Decrease the evening dose of NPH — somogi effect
2.Increase the evening dose of NPH — pawn phellomene.
3.continue with same doses and eat a sugar snack at 3am. 4.continue with same doses but eat a sugar meal at bed time..kuch is tarah ki options thi

Normal cardiac output = 5 L/min.

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control.HBA1c is 6.8 I think.Creatinine is 4.5.Now what should his diabetes be managed

1.continue with the same sulfonylurea
2.insulin plus glucose
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Septic shock
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Pregnant lady with chest pain and SOB (forgot rest).
O/E Pedal edema and tender liver . ECG RAD.
Forgot full hx and labs.
I think it was Pulmonary stenosis

Q no1. Which of the following hormones are released from the anterior pituitary?
Prolactin b) ADH C) TSH C) Oxytocin

A young lady with mass on USG in liver
HCC
nodular hyperplasia
hemangioma
cyst
hepatocellular adenoma

Patient on MDR therapy develops skin tanning
BP 100/70
No postural drop
Young lady husband died 2 days ago presented with decreased thirst, Polyuria

acute MI
Improves outcome

CMDT – 484.

cardiac Index < 2.2 L/min/m² = Cardiac shock.

Cardiac Index = cardiac output / BSA.

Normal cardiac Index = 2.5–4 L/min/m²

Normal cardiac output = 5 L/min.

Dawn phenomene.
Somogi effect
Dawn phenomene.

Pul A HTN
Cardiomyopathy
Rt Atrial pr.

CO = SV x HR

Normal CVP = 0–5 cm H2O.

Ant pit
GH, ACTH, TSH
FSH, LH, PRL

Post Pit.
ADH
Oxytocin

CVP > 12 cm H2O = Hypervolemic or cardiac failure.

Normal PCWP → 4–12 mm Hg.
PCWP > 18 mm Hg.
= Lt Heart failure

Pul A pr
Sys = 20–30 mm Hg
Diastol – 8–12 "
Mean = 25 mm Hg

Cardiogenic Shock
BP < 90 mm Hg
CI = < 2.2 L/min/m²
PCWP > 15 mm Hg

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Oligoclonal bands in CSF but not in serum = MS.

Reviewed by Dr Iffat Hanif.

forgot rest. What will you do
1. RBS
2. Urinary Na
3. Serum and Urine Osmolality simultaneously
4. Urine Osmolality
50 years lady of 2 kids with LBP severe in nature and lower limbs weakness. O/E power was low in lower limbs(i think 4/5 but i forgot.
Her Calcium was (3.2), Alkaline phosphatase was raised and phosphate (i forgot).
Most likely diagnosis
1. MM
2. Osteoporosis 3. Mets from breast
4. Spinal stenosis
I forgot 5th one
sacroiliatis and patient feels very pain on flexion and on rotation (like fracture). Forgot full Hx.
Best treatment
some orthopedic options I forgot all
70yrs lady with above hx.compared to previous xrays, the disease has progressed.now she is in pain with above posture..wat to do.
MRI spine
Ref to rheumatologist for med mx
ref to ortho for total hip replacement.
A patient being treated for drug resistant TB.He developed pigmentation of skin.cause
Anderson disease.
Tb drugs
hemochromatosis
Pregny lady in 3rd trimester with signs and symptoms of anemia (Given in Hx). Labs show HB 6.5(some value like this), normocytic normochromic anemia with few target cells.
Diagnosis
1. Thalassemia intermedia
2. ~~IDA~~ Iron Def. Anemia
3. Folic acid deficinecy 4. Vit B 12 deficinecy
Forgot other option
Patient with right Ptosis and normal pupil with normal reaction to light.
Diagnosis
Partial 3rd nerve palsy
Forgot other options
Coumarin induced skin necrosis occurs in
protein c def

Pagets → Deafness, High output failure
↑↑ Alk phosphatase
↑ Hydroxyproline in urine

Osteoporosis - Normal Ca, PO_4, Alk Phos.
↓ bone Density

Osteomalacia - ↓ Ca & PO_4, ↑ Alk Phos.

MM — ↑ Ca, Normal PO_4.

Ca =
PO_4 =
Alk phos =

AS → [Best initial Rx = NSAIDs. swimming also good

↳ clofazimine → skin pigmentation

→ glycogen storage disorder

↳ Thalassemia ← Tear drop + target cells
myelofibrosis — Tear drops cells.

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Warfarin inhibits — 2, 7, 9, 10, Protein C & S — Protein C $t_{1/2}$ = 6 hours

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MRI spine
Ref to rheumatologist for med mx
ref to ortho for total hip replacement.
A patient being treated for drug resistant TB.He developed pigmentation of skin.cause
Anderson disease
Tb drugs → clofazimine → skin pigmentation
hemochromatosis → glycogen storage disorder
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Diagnosis
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Forgot other options
Coumarin induced skin necrosis occurs in
protein c def
antithrombin III def
dysfibrinogma
factor v def
Patient with biopsy proven Ca esophagus now planning for Surgery. Most appropriate step
1. CT thorax → CT thorax IAnd ± PET CT ± laproscopy.
2. CBC
3. CXR
4 MRI — ~~not~~
30 years sexually active man with right knee pain. O/E no signs of inflammation but having effusion. Aspirated showing WBC 30000 and .(no rashes were mentioned)
Diagnosis
1. Reactive arthritis
2. Gonococcal arthritis
3. OA 4. Gout
↓
non Inflam WBC < 2000
↳ Inflam – 2000 – 50000.

PO_4 ↑
Alkphos ↑

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Thalassemia → Tear drop + target cells
myelofibrosis – Tear drops cells.

Warfain inhibits – 2, 7, 9, 10, Protein C & S – Protein C $t_{1/2}$ = 6 hours
Warfain → skin necrosis 2° protein C Def.
cellulitis 2° ca Deposition in BV.

Tear drop
1. myelofibrosis
2. Thalassemia

Target cells
1. – Thalassemia
2. – post splenectomy
3. – SCA.
4. – Hb H, Hb C.
5. Iron Def Anemia

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III palsy < with contralateral Hemiplegia (Corticospinal T) → Weber
< with contralateral ataxia / Tremor (Cerebellum) – Benedikt

Benedikts → paramedian Br of

6

40 years old Patient smoker with Cough,Dyspnea and LOw BP low pulse. (Forgot other HX).
ABGs show PCO2 55, PH 7.25, Bicarbonate 12,Cl 112. Na 131.
Diagnosis
1. Respiratory acidosis with metabolic alkalosis
2. Respiratory acidosis with metabolic acidosis
3. Respiratory alkalosis with metabolic acidosis 4. Respiratory acidosis with respiratory alkalosis
Patints with Chest pain ,raised JVP and B/L wheezes on chest exam,pedal edema and Tachaycardia with irregular pulse. ECG shows Multifocal PACs etc . On ACEI, aspirin and statin. BP was normal. Deranged RFTs.
Most appropriate treatment
1. Atenolol
2. Diltiazem
3. Verapamil
4. Prazocine

} cardiology

PCB – Pakistan Cricket Board

PH say – Acidosis
↑ CO_2 says – Resp. Acidosis
↓ Bicarb say – Acidosis

Bicarb & Co2 are in opp Dir
= Mixed

lady diabetic, on regular insulin and NPH, with good control of diabetes.She is strictly adherent to dietary advice and exercise.but her early morning sugar remains high.blood sugar level chart given.At 2 pm 90.at 8 pm ?115.at 8am 215.What strategy you will tell her.
1.Decrease the evening dose of NPH
2.Increase the evening dose of NPH
3.Continue with same doses and eat a sugar snack at 3am. 4.continue with same doses but eat a sugar meal at bed time..kuch is tarah ki options thi

for somogyi they will give value of mid night hypoglycemia

16 years boy with Seizures . O/E some nodules on nasolabial folds and face and some plaque type rash in back and subungual fibromas.
Family HX negative.
Diagnosis
1. Von Recklingausan disease
2. Tuberous Sclerosis 3. Sturge weber
4. Osler rendu weber Syndome
Forgot others
But NF was not there.

↳ Shagreen patches
↓ adenoma sebaceum

Low Complement GN

MPGNS

MPGN
Post strept GN.
SLE

A

Achalasia

Initial Test = CXR
Barium Swallow
Confirm → Manometry
Pre-op – ~~esophageal~~ upper GI endoscopy

about HDL. Alfa lipoprotein. The options were.
Abetalipoprotenemia.
Type 1 dyslipidemia
Type 2 dyslipidemia
Lipoprotein lipase deficiency

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contraindication to mechanical ventilation.
Inc resp rate
Prolong expiration
Inc residual volume
Vital capacity

Neutrophils
< 1800/ml or < 1.8×10^9/L
= Neutropenia

PICA SYNDROME/Aclasia on barium meal confirm by manomatry/pt with ptosis opthamoplegia with dry

→ severe neutropenia if < 500/

AICA
PICA
– WEBER
BENEDICT

+CCl
+Gf

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16 years boy with Seizures . O/E some nodules on nasolabial folds and face and some plaque type rash in back and subungual fibromas.
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⇒ about HDL. Alfa lipoprotein. The options were.
Abetalipoprotenemia.
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⇒ contraindication to mechanical ventilation.
Inc resp rate
Prolong expiration
Inc residual volume
Vital capacity

⇒ PICA SYNDROME/Aclasia on barium meal confirm by manomatry, pt with ptosis opthamoplegia with dry mouth Lambert Eaton, one Q was about wiple treatment options antibiotic, positive bifregance crystal in osteoarthritis, on q deformed RA with neutropenic spleen felty, recurrent haematuria with low complement gud pasture, one was INFECTIVE ENDOCARDITIS, PREGNANCY WHICH NOT Suitable CAPTOPRIL, YOUNG healthy Male recurrent jaundice with spleen unconjugate bilirubinema GILBERT, TWO senario pt recurrent rt hypochondrium pain raise alkaline phosphatase who diagnose by endoscopy Gi PROBLEM PSC, pt with small n large pain at time of episodes of diarrhea IBD
CSf
No

↳ Shagreen patches

↓ adenoma sebaceum

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Neutropenia
< 1800/mL or < 1.8 x 10^9/L
= Neutropenia
→ severe neutropenia if < 500/mL or < 0.5 x 10^9/L

Achalasia
Initial Test = CXR
Barium Swallow
Confirm → Manometry
syndromes
Pre-op - ~~esophageal~~ upper GI endoscopy

- AICA
- PICA
- WEBER
- BENEDICT

HCC
~~HGE~~
Unions - Hemolysis
Gilbert
Crigler Najjar
CDR
Conj - Dubin Rotor

CMDT - 620 (2015) -
Rx of Whipples - Ceftriaxone - 1 g IV x BD
or Meropenem - 1gm IV TDS
} 2 wks
Follow by Trimethoprim/Sulfamethoxazole 160/800mg - BD for 1 year

Post Rx -
Duodenal Bx
+ CSF PCR.
6 monthly for 1 year

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Normal CSF

IOP
Normal =

Cells were 5
All lymphocytes
100mg protein 40mg sugar
This was exact
What treatment to start with Iv acyclovir
Iv benzyl penicillin
Iv quinine
Iv steroids
Patient with inferior wall MI received SK with HR 40 and BP 100/70.
Best initial treatment
1. Atropine
2. Temporary pace maker
3. Cardioversion

Pace Maker if
BP < 90
pauses > 3 seconds.

10 years of RA.She never went into remission.currently on leflunamide.develop leg swelling,abdominal distension and facial swelling.cause?
amyloidosis
nephrotic syndrome.
Retrosternal intermittent sharp pain.He has cough and low grade fever.
MI — sudden onset - constant
Pulmonary embolism — pleuritic chest pain
acute pericarditis — sharp retrosternal pain, may develop in hours to days or intermittent. Pain ↑ if lying down ↓ with sitting up
costochondritis — tenderness of the costochondral junction
High dose ascarbic acid to prevent cold
1.false urine bilirubin
2.false urine glucose
3.high urine gravity
2nd option correct
all features of GBS. →
Most common finding → GBS pt mostly have raised proteins in CSF & normal CSF cell counts.
1. Raised CSF protiens
2. Lymphocytosis
3- protein
↑ Protein and ≤10 mononuclear cell → likely Dx = GBS
Diabetic with productive cough and fever.Antibiotic?
Cefuroxime
septran
cloxacillin
flucloxacillin
ampicillin
Dr Hathim.
Patient with renal dysfunction and pulse i think 100 and BP was 70/50(like shock).
Diagnosis
1. Septic shock
} shift to shock question

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1.false urine bilirubin
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Diabetic with productive cough and fever.Antibiotic?
Cefuroxime
septran
cloxacillin
flucloxacillin
ampicillin
} Dr Hathim.
Patient with renal dysfunction and pulse i think 100 and BP was 70/50(like [illegible]).
Diagnosis
1. Septic shock
2. Venous pressure 3 cm of water
CVP – } shift to shock question
Forgot other options
Heavy Alcoholic patient with pain RHC,jaundice and malaise, vomiting (Forgot rest HX).
His labs show ALT 980,AST 350(some values like these but ALT was much more elevated than AST)
S.Bilirubin was 5. Alkaline phosphatase was also raised (but forgot the value)
Diagnosis
1. Alcoholic hepatitis
2. Fatty liver 3. Viral hepatitis
Most important predictor of successful resuscitation
Options
Pulse < 100
RR< 16
bp > 100 systolic
urine output more than some value was given.
} check.
Best predictor of outcome
✓ end tidal CO_2 ($ETCO_2$) following 20min of resuscitation
↳ 10 = Bad.

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26) Young patient with painful eye and sudden loss of one eye vision? crvo,MS,retinal cerebritis etc

27) A nurse has plasma osmolality of 280 and urine 290..after deprivation urine osmolality is 600.. cause

Psychogenic DI Lithium toxicity Cranial DI Nephrigenic DI

28) Patient with siadh hx (ca lung or head injury) no hypotension , edema , dehydration , Na 118 treatment 1. Fluid restriction 2. N saline 3. 3% saline 4. IV frusemide

29) Subclavian steel syndrome

30) pedal edema,ascites,raised jvp,normal heart,low voltage QRS complexis?ccf,corpulmonale,constrictive pericaritis

31) 12 y boy who gradually developin last the 6years, with proximal muscle weaknes of limbs and pelvic girdle.Dx. Limbgirdle type dystrophy Facioscapulohumoral

32) Pt.with steatorhhea,non pit edema and ascites..dx. Celiac? Intestinal lymphamgiectasia

33) Pt with qrs complex broadening and tall tented t waves what to do I v calcium or lab

34) Diabetic patient with giddines and occasional vomitting,sweating..Dx. Autonomic neuropathy Peripheral neuropathy

35) Young boy with trauma to leg..orthopedic surgeon advised rest.he developed sudden onser SOB and tachy..ecg shows sinus tachy..cxr showed left sided small pleural effusion with pleural rub on examination..Dx PE Spontanous pneumothorax Fat embolism

36) Pat on treatment of HTN, ATT , ca 11.2 , cause 1. Thiazide 2. Rifampicin 3. Isoniazid

37) Female with recurrent abortions for 10 years,has one alive son,aptt 46 sec..dx.is .plz complete te senario Apls SLE Torch inf

38) Diabetic patient on insulin started on propranolol developed hypoglycemia. What shud be done A. Reduce actrapid B. Reduce long humulin C. Reduce propanolol D. Stop propranolol

39) After an illnessa boy developed swelling of left knee and right ankle..dx. Reactive arthritis Gout

40) Pt.had severe diarrhea and he took metronidazole but developed ARF or something happened to him.dont remember..dx. HUS?

41) SLE pt.with fits and unconsciousness.fits controlled with diazepam,has hypodense lesion on CT scan..next apropriate step?kindly complete this senario.. Prednisone

42) Patient with secondary amenorrea,soft skin,lethargy...Dx. Addison Sheehan Primary hypothyroid

43) [illegible] peripheral lung infiltrates on cxr diagonosis? Sarcoidosis

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44) Hx of recurrent TIAs, with hemiparesis n visual loss .o/e normal neurological exam , 80 % internal carotid stenosis Options for treatment 1. Aspirin 2. Warfarin 3. LMWH 4. End artectomy

45) Htn with hypokalemia treatment of choice? Spironolactone

46) Cryptococcal neoformans?

47) TOF?

48) RA with paresthesia n rt foot drop , treatment 1. Steroids 2. Surgical intervention 3. NSAID , metho , steroids

49) Pt.with upper GI bleed,endo shows varices,no hepatomegaly..tx.to prevent recurrent bleed Propranolol

Banding Sclerotherapy

50) Pt.stool RE shows eggs of ankylostoma deudonal.tx.is Praziquantel Albendazole

51) Patient in surgical ward hypotension , fluid 1.n saline 2. 0.45 saline 3. RL 4 . Haemacel

⇒ CPSP has a shamefully low passing rate.

⇒ Raise your voice for your rights—
⇒ Join us; - 0346-4455666

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52) Pt.has hemoptysis and cXR is normal..FBC normal.next to do is? (Dnt remember exact senario)..help me in recalling it. Bronchoscopy Ct chest Sputum analysis Mediastinoscopy Clotting profile

53) Hcv positive pt.with ascites and abdominal pain..diagnostic tap showed 75% neutros..pt.will benefit from Iv antibiotics Therapeutic tap Transjugular shunt..i hope this was the scenario

SBP — Definition. Ascitic fluid TLC > 500 & Neutros (PMN cells > 250).

54) Patients ACTH levels raised and cortisol raised..low dose dexa dint supress but high fise dexa did suppression..next todo MRI pitutary. → ant. pit hormone.

55) pt with h/o fever drenching night sweats n wt loss cxr normal does anyone remember? Brucellosis

CLL

56) Tdt positve and negitive etc Burkitt Mucoid fungoides ~~CH~~ Lymphatic → TdT positive = ALL

57) Rabbit bite 1. Rabies immunoglobulin 2. Vaccine 3. IV antibiotic 4. Vaccine + immunoglobulin

58) Scenario on Wilson disease

Raise your voice for your rights!

59) Autoimmune hemolytic anemia with platelet count 60000, what is Dx? Evans syndrome

60) there was schedule of rabies vaccine asked I think 0 3 7 14 28 days

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61) Pt.with smoking,htn and sudden onset abdominal pain..dnt remember exact senario..but it was i think Atherosclerotic aortic dissection

62) Pt having history of confusion loss of vibration sense absent ankle and extensor planters diagnostic investigation? B12

63) Diabtic with diarrhea Loperamide?

64) Pt.with radio radial and radiofemoral delay..cause is Coarctation of aorta before origion of subclavian artery Descending aorta coarctation

65) Renal involvement , immunofluroscence shows igm , C3 deposition 1. Minimal change 2. Diabetic nephropathy 3. SLE 4. Cryoglobin

66) Patient with right hypochondrial pain of gradual onset,developed jaundice and fever..palpable mass in rt.hypo..dx. Choledochal cyst Biliray atresia Hydatid cyst Hepatic cyst Reidel lobe of liver

67) Pt with ho of rash and low plt investigation of choice

68) Patient has resp infecton n tk clarith for it Rti resolved then develop renal failure
Ciclosporin toxicity CmV infection Acute rejection

69) Smoker with 2 yrs gradual onset hx.of pain and stiffness in both legs when he walks for 10 min..his pain relieves wd rest..pulses palpable..dx. Spinal stenosis Peripheral vascular disease Disc prolapse

70) Alport syndrome wala senario kya tha? Family history of renal disorder and common in males? With lense dislocation,hearing loss?

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Choledochal cyst Biliray atresia Hydatid cyst Hepatic cyst Reidel lobe of liver

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70) Alport syndrome wala senario kya tha? Family history of renal disorder and common in males? With lense dislocation,hearing loss?

71) smoker who had hemoptysis.and cxr showed left hemidiaphragm raised with left hilar enlargement.next to do Broncho Ct chest Sputum analysis Mediastinoscopy

72) Pt.with HTN and had yellowish lesions on elbows..do Fasting lipid profile Skin biopsy

73) IE strep viridans , sensitivity to penicillin , but pat is allergic wat antibiotic to use 1. Ceftriaxone , 2. Vanco 3. Genta

74) Two weeks after delivery lady presented with unconciousness and rt sided weakness, o/e she can not move rt half of her body , rt plantar extensor, fundus ok , csf 1200 cells 60%polys what invest u do for diagnosis 1. Ct brain 2. Mrv 3. Mri with contrast 4. Csf analysis

75) Pt with ho of diarrhoea for last 10 yr now jaundice with pruritis alp increased ama negative diagnosis? PSC

76) Ho joint deformity with Charcot joint with decrease sensations and reflexes.DM

77) Pt with Graves opthalmoparhy drug of choice? Steroids

78) female with history of renal disease farher n uncle died of renal disease what to do? usg+?++

79) CRF pt.with 6 months tx of oral iron..now Hb 10.7.. what to do S/c erythropoitin S/c erythro plus iv iron Continue oral iron CALLA is present on Mature cells.

80) Upper lobe fibrosis R.A Scleroderma Ankylosing spondylits

TDT positive — ~~ALL~~, ~~for~~ for immature B and T cells.
like ~~ALL (B)~~ / ~~AML~~ — ALL >> AML. ~~It~~ It is negative on mature cell lymphomas like Burkitt. Hairy cell leukemia ; CLL (B + T Both) ; B/cell lymphoma ; mycosis fungoides

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Copy

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POISONINGS
```

LITHIUM

- ***Kidney*** - Nephrogenic Diabetes Inspidus, FSGS, AKI
- ***Thyroid*** - Hypothyroidism
- ***CNS*** - Coarse Tremors, dysarthria, nystagmus , Hyperreflexia
- ***CVS*** - Low BP, brady, Blocks, Prolongation of PR or QT

```
MONITORING
```

- – (for patients taking regular doses) – Thyroid and RFTs 6 monthly
- – Lithium levels (draw sample after 12 hours after the dose)
- – – ***Mild-Moderate toxicity*** – levels 1.5-2.5 mEq/L
- – – ***Severe toxicity*** – levels above 2.5 mEq/L
- ***FINE*** tremors in chronic toxicity, ***COARSE*** in acute toxicity (***side note*** – cyclosporine - coarse tremors)
- Other important points – High Calcium, Low Mg, weight gain

```
TOXICITY
```

- precipitated by dehydration, diuretics, renal failure and Drugs (NSAIDs, ACE, CCB, Metronidazole, Methotrexate)

```
MANAGEMENT
```

1. Scene safety and removal
2. ABC and supportive care - give i.v fluids
3. Gastric lavage or whole bowel irrigation
4. ***alkalinization of urine***
5. Hemodialysis (at level above 4, or CNS or CVS features)

- – ***Charcoal is ineffective***
- – ***Lithium contraindicated in Myasthenia and Psoriasis***

DIGOXIN

- used in AFib for rate control (slows AV conduction and stimulate Vagus nerve)
- for inotropics effect (inhibit Na/K ATPase), improves symptoms in failure but doesnt improve mortality
- first order kinetics half life 1.6 days. 25% of plasma drug is protein bound.

```
LEVELS
```

1. Therapeutic range = 0.5-0.9 nanogram/ml
2. Toxicity = usually above 2 nanagram/ml

```
TOXICITY
```

is precipitated by

1. ***hypo*** (kalemia, mg, thyroid, thermia)
2. ***Hyper*** (natremia, calcemia)
3. ***Drugs*** (Amiodarone, Verapamil, Beta Blockers, Spironolactone, SSRI, drugs causing Hypokalemia - thiazide and loops)
4. ***Systemic diseases*** – (CKD, MI, Hypothyroidism
5. Advanced age

```
FEATURES
```

- ***GIT*** (Nausea, vomiting) – *usually the earliest symptoms are GI-symptoms*
- ***CNS*** (Headache, Dizziness, Irritability, yellow vision)
- ***CVS***
- Arrhythmias - could be almost any type

- ECG - PR prolonh, QT shortening, reverse tick down slopping ST depression, inverted T, Tachy brady arrythmias)

```
MANAGEMENT
```

1. Scene safety and removal, stop the drug,
2. ABC and supportive care – treat the ppt factor

- – – – ***if present*** – Correct Hypercalcemia, Hypernatremia, Hypomagnesemia
- – – – Keep Potassium in range of 4-5.5

3. Give phenytoin or Lidocain
4. ***Digixin Specific Antibody*** – (Digiband)

- if BP unstable
- Arrythmias (persistent brady or vent Arrythmias)
- Potassium above 5
- Digoxin level above 13nmol
- ingestion more than 10mg

5. General measures - Charcoal, etc

```
NOTES
```

- – Amiodarone is contraindicated
- – Shock only considered when all else has failed
- – Digoxin contraindicated in amyloisdosis)
- – ***Digiband*** - *exact dose is calculated by serum level, Ingested amount and body weight. if none specified, then in acute toxicity empiric adult dose is 10-20 vials of 40mg, and in chronic toxicity 6 vials of 40mg, prepared in sterile water then diluted in normal saline and given i.v over 20-30 minutes.* – may repeat, and commonly upto 20 vials are needed.

SALICYLATE POISONING

- For exam purpose, scenario usually focus on ABGs - ***mix disorder*** - First Respiratory alkalosis and then HAGMA (High Anion Gap Met Acidosis)

- ***Acute*** – ingestion of 150mg/kg

- ***Acute and severe*** – ingestion of more than 300mg/kg

- ***Chronic*** – Repeated high dose intake

```
PRESENTATION
```

- ***Resp*** - Tachypnea, hyperventilation, Non-Cardiogenic Pulmonary Edema
- ***CNS*** – Tinnitus (early), Deafness, Seizures, cerebral edema, coma
- ***GIT*** - Nausea, Vomiting, Pain
- ***Electrolytes*** - Low potassium
- ***Others*** – Sweating, Hyperthermia, Rhabdomyolysis, Thrombocytopenia, DIC
- ***RBS*** - can be high or Low

```
INVESTIGATIONS
```

- Serum levels
- ABGs - ***pH close to normal, HCO below 18, CO2 below 35***
- CBC, LFT, RFT, RBS, Electrolytes
- Urine pH

```
TREATMENT
```

1. Scene safety and removal, Stop the exposure
2. ABC and supportive care
3. charcoal if in 1-2 hours – 1gm/kg

- – – *Can also consider Multi-Dose activated charcoal*

4. ***Urinary alkalinization***

- – – if level 450-700 (give soda bicarbonate but ***NEVER*** in cerebral and pulmonary edema)
- – – ***Target*** - Urine pH 7.5-8.5 and Serum pH 7.45-7.55

4. ***Dialysis***

- – – (If involvement of Kidney, heart, CNS)
- Serum level above 700
- Resistant Met Acidosis
- AKI

- Pulmonary Edema
- CNS

```
MONITORING
```

- Urine pH - keep above 7.5
- Urine output - more than 1ml/kg/Hour
- Drug level (in mg/L) - below 250 is mild, 250-500 is moderate, 500-700 is severe, above 700 is fatal
- Electrolytes 2-4 H
- – ***level 450-700 mg/L (or 45-70mg/dL*** ➡ Urinary alkalinization – give soda bicarb
- – ***Level above 700 mg/L (or 70mg/dL *** ➡ dialysis
- *– Chronic toxicity often has a lower threshold for dialysis - like 600mg/L (or 60mg/dL)*

PCM OVERDOSE

```
PHASES
```

1. ***0.5-24 Hours*** – Nausea, Vomiting
2. ***24-72 Hours*** – Abdominal pain, Hepatomegaly, Oliguria
3. ***72-96 Hours*** – Jaundice, Coagulopathy, Encephalopathy and hypoglycemia
4. ***4 Days to 02 weeks*** – Recovery (if patient survives), or progression to death

```
POINTS
```

- dose more than 150mg/kg (or 8-10gm in 24 hours) or Repeated Supratherapeutic doses (more than 4gm/day for more than 48 Hours), ***staggered*** - excessive dose over 24 hours
- – – risk increased if Anorexia nervosa, Alcohol, HIV, taking p450 inducers, Hepatotoxic drugs

- – – Check levels at 4 hour, not earlier

- – – *Normal conjugation is glucoronic acid, when this is saturated, then oxidation occurs - NABQI accumulation which is toxic - conjugation then with glutathione - when glutathione consumed - toxins bind with cell proteins - *Liver and kidney*

```
INDICATIONS FOR ACETYLCYSTEINE
```

- (precursor of glutathione)

- Hepatoprotective if started within 8 Hours

1. if PCM taken in ***Staggered dose***
2. ***4 hour level above 100 or 15H level above 15mg/L***

- IV Given as slow infusion in 5% dextrose (150mg/kg in 250ml in 1 hour, then 50mg/kg in 500ml in 4Hr, then 100mg/kg in 1 Litre in 16 hours)

- ORAL 140mg/kg, then 70mg 6 hourly 17 doses

- Side effects - Nausea, vomiting, itching, Urticaria, Hypoglycemia, ANAPHYLAXIS, HYPOTENSION

- ***if minor side effects*** - stop, give Antihistamine and restart

- ***if Significant allergic reactions to acetylcysteine*** - (anaphylaxis, hypotension) – then METHIONINE oral can be used

```
LIVER TRANSPLANT
```

- (Referral if INR above 2 @ 48 hours, or above 3.5 @ 72 hours)

1. ***pH*** below 7.3, after 24 Hours , or after resuscitation (or lactate above 3.5 after fluid resuscitation)

2. ***All three*** of (PT above 100, Creat above 300, Encephalopathy grade 3-4)

```
TRANSPLANT IN OTHER POISONING
```

- 1. – INR above 6.5
- 2. – 3 of these 5
- age less than 11 or more than 40
- INR above 3.5
- bilirubin 300
- Jaundice to encephalopathy gap less than 7 days
- Non-A, Non-B Hepatitis, Idiosyncratic drug reaction

- – – – ***Drug toxicity DDs*** - *infection - Hepatitis, leptospirosis, Metabolic Encephalopathy, Ethylene Glycol*

BDZ OVERDOSE

- BDZ potentiate inhibitory affects of GABA by facilitating its binding to receptors ➡ Slurred speech, ataxia, Altered Mental Status

```
        MANAGEMENT
```

- – Supportive and Flumezinil (though its not used commonly due to side effects like SVT, and seizure)

```
PROPYLENE GLYCOL POISONING
```

- it is diluent used in iv preparations of lorazepam and diazepam and it should be kept in mind that side effects after these iv injections could also be due to Propylene Glycol ➡ Tissue necrosis, hemolysis, Arrythmias, multiorgan dysfunction

---

OPIOIDS POISONING

- opioids are AGONISTS at,

1. ***Mu receptors*** - Analgesia, Euphoria, bradycardia, GI dysmotility, Resp depression
2. ***Kappa Receptors*** - Hallucinations, Miosis
3. ***Delta receptors*** - Pain and mood

- – – – Opioid effects (pain relief and side effects like respiratory depression, addiction) are primarily due to agonistic effect on ***Mu Receptors***

```
    FEATURES
```

- ***CNS*** – Lethargy, Sedation, altered sensorium, coma, Miosis

- ***Respiratory*** – Bradypnea, Hypoventilation, Apnea, Non-Cardiogenic Pulmonary Edema, Respiratory Arrest

- ***CVS*** – Bradycardia, Hypotension, Arrhythmias, Arrest

- ***GIT*** – Gastric aperistalsis (Nausea, Vomiting, Constipation)

- ***Others*** – Urinary retention, Pruritus, Flushing, Hypothermia

```
MANAGEMENT
```

1. Scene safety and removal, stop the exposure
2. ***ABC before antidote***

- – fluids

3. Antidote ,– Acute - ***Naloxone*** 0.4-1mg - can repeat in 3-5 minutes (may need upto 20mg dose) – ***Target*** – Adequate Ventilation

- – – – ***if no iv access*** - give 2mg i.m
- – if Chronic/dependance - ***Naltrexone*** is given

TCA POISONING

- – Inhibit presynaptic reuptake of norepinephrine and serotonin
- – Acute ingestion more than 1gm causes severe toxicity
- – ingestion of 10-15mg/kg is life threatening
- – Elderly, underlying cardiac, renal or hepatic diseases are precipitating factors

1. ***CVS*** - Sinus Tachycardia, Long QT, VT/VF, Wide QRS, Brugada

- – – ***(hypotension is primary cause of mortality)***

2. ***CNS*** - Sedation, Seizures, Coma

3. ***Anti-cholinergic*** - Hyperthermia, Dry mouth, Flushing, dilated pupil, ileus, Urinary retention

```
TOXICITY
```

- (cause receptor blockage)

- – ***Alpha Receptors blockage*** - ➡ Vasodilation ➡ Hypotension

- – ***Histamine receptors Blockage*** - Drowsiness, coma
- – ***Muscarinic receptors Blockage*** ➡ anticholinergic effects ➡ fever, tachy, Dry mouth, dry skin, dilated pupils
- – ***FAST SODIUM CHANNELS blockage*** - LONG QT, VT
- – ***URINARY RETENTION*** - distended Bladder

```
TREATMENT
```

- ***Monitor*** - Cardiac monitor, Vitals, GCS, ABGs, Electrolytes
- ECG is the best predictor of severity
- ***Antidote*** – No specific antidote for TCAs

1. ABC
2. Oxygen
3. Saline bolus for hypotension

- – – ***refractory hypotension ➡give norepinephrine***

4. Activated charcoal - consider if ingestion time > 02 hours

- – – *Gastric Lavage - consider only if life threatening ingestion and presents within 1-2 hours*

5. Seizures control with BDZ

- – – Acidosis increases the risk of CVS and CNS toxicity hence ***MAINSTAY OF TREATMENT IS SODABICARB***
- ***Bolus*** – 1-2 mEq/kg iv push (and repeat if QRS remains wide)
- ***Infusion*** – 3 ampoules (= 150 mEq in 1000ml 5% Dextrose and give at rate of 150-250ml/Hour)
- – – ***Goal*** – keep pH 7.5-7.55, (when pH is above 7.55 ➡ stop infusion, and may restart when pH falls)

```
INDICATIONS OF SODA BICARB
```

1. PH below 7.1
2. QRS more than 100
3. Arrythmias
4. Hypotension

- – refractory Arrythmias then can give iv Glucagon or MgSO4
- – – Can also consider lidocaine WITH CAUTION
- – keep pH on higher side - 7.5 to 7.55

- Neuroleptic Malignant Syndrome and Serotonin Syndrome

1. Hyperthermia (and sequelae like Rhabdomyolysis, DIC, AKI)
2. Tachypnea, Confusion, agitation, rigidity, Coma
3. Elevated CK, RFTs, Leukocytosis

- ***rigidity*** - Prominent feature in NMS but late and mild in SS
- ***Reflexes*** – Hypo or normal in NMS but Hyperreflexia in SS
- ***Clonus*** – no clonus in NMS but hallmark of SS
- ***Pupil*** – Normal in NMS but dilated in SS
- ***GI symptoms*** – common in SS
- ***Reaponse to BDZs*** – partial in NMS but dramatic in SS

```
NMS
```

- Dopa is decreased
- Antipsychotics given (Haloperidol, Resperidone) or anti parkinson stopped
- ***Develops in days to weeks***
- Features like Parkinson - ***Ts*** Tone/(rigidity), Temperature (Hyperthermia), Tachycardia
- ***Normal reflexes, Normal pupil***
- Renal failure predicts mortality

```
MANAGEMENT
```

1. ***First line*** – for rigidity - BDZ
2. ***Second line*** – if no response to BDZ then Dantrolene is second line.

- – – *Dopamine agonists are also second line (Bromocriptine, amantadine)*

3. ***Third Line*** – Electro-conbulsive Therapy (ECT)

```
SEROTONIN SYNDROME
```

- MAST drugs (MAO , Amphetamine, SSRI, Tramadol)
- ***Develop in less than 12 Hours***
- – (Think of features like pheochromocytoma) - Tachycardia, Hypertension, sweating, Flushing, Diarrhea, Hyperthermia
- – – ***hyperreflexia, Clonus and Extensor plantars, Myoclonus, Dilated pupil***

```
MANAGEMENT
```

- Discontinue culprit drugs
- Supportive care
- ***First line*** are BDZs for agitation, rigidity and seizures
- ***Second line*** – Cyprohepatidine
- ***Third Line*** – chlorpromazine

WHEAT PILL

- Aluminum Phosphide
- – – *(some preparation have Zinc Phosphide which is toxic but comparatively less lethal - mortality 25-40% whereas Aluminum Phosphide mortality is more than 90%)*
- – – *Phosphine gas (hence garlic smell) is released on contact with moisture or acid in stomach ➡ Toxic effects inhibit cellular oxygen utilization and cause mitochondrial injury*
- ***GIT*** – Vomoting, Pain and GI Bleed, Pancreatitis
- ***CVS*** – Arrhythmias, circulatory shock
- ***Respiratory*** – Tachypnea, Hypoxia, Cyanosis

- ***CNS*** – irritability, Confusion
- AKI, Hematuria, Metabolic acidosis

```
MANAGEMENT
```

- Supportive Care
- i.v fluids, Vasopressors, Inotropics
- consider Soda-Bicarb if pH is low
- MgSO4 - may have protective role against oxidative stress
- Ventilator support
- Consider Dialysis if renal failure or refractory acidosis

CYANIDE POISONING

- Insecticide, photographers, Fireman
- – – Blocks cytochrome oxidase C - inhibit cellular respiration - - no ATP - Histotoxic Hypoxia

```
PRESENTATION
```

- ***with inhalation*** – symptoms appears quickly, within minutes
- ***with ingestion*** – onset of symptoms may be from minutes to hours
- Brick red skin, Almond smell
- ***CNS*** – headache, confusion, seizures, DILATED PUPILS, coma
- ***Respiratory*** – Tachypnea early, then bradypnea, Hypoxia, respiratory arrest
- ***CVS*** - Hypertension earlier, then Hypotension, Arrhythmias, CVS Collapse, Cardiac arrest
- ***GIT*** – Nausea, vomiting, Cramps
- ***Severe lactic acidosis***

- Chronic – Ataxia, Neuropathy, dermatitis

```
TREATMENT
```

- ***Monitor*** – continuous cardiac monitor, Vitals, Pulse oximetry, ABGs, Lactate levels

1. Scene safety, rescue from scene, decontamination (e.g. remove cloths)
2. ABC and supportive care

- 100 % oxygen, Airway management (if needed, intubate), iv fluids, if hypotension then give Vasopressors

3. ***First line antidote*** - HYDROXOCOBALAMIN (Cyanokit) – adult dose 5gram i.v in 15 minutes and may repeat once.
4. ***Second line*** - if Hydroxocobalamin unavailable – SODIUM NITRITE – adult dose 300mg i.v in 2-4 minutes
5. ***Adjunctive therapy*** – (with HYDROXOCOBALAMIN or SODIUM NITRITE) – 12.5 gram i.v
6. ***Amyl nitrate*** – is pre hospital temporizing measure

- ALTERNATIVE FIRST LINE ANTIDOTE ***DICOBALT EDETATE***

CO POISONING

- Firesmoke inhalation, Malfunctioning heating systems, Vehicle exhaust in close space (Garages), Industrial exposure in foundaries and mining blast fumes, Heaters in winter

- Saturation normal but Oxygen partial pressure is low (because pulse oximeter can't differentiate between oxy and decarboxyhb and sense it as normal saturation)

- ***Cherry Red skin, Pink mucosa***

- ***CNS*** – Headache, vertigo, confusion, seizures, Coma

- ***CVS*** – Chest pain, palpitations, Hypotension, Arrhythmias

- ***Respiratory*** – Tachypnea, Non-Cardiogenic Pulmonary Edema, respiratory arrest

- ***RENAL*** – AKI, Proteinuria

- ***Hematological*** – Leukocytosis, TTP, DIC

- ***Musculoskeletal*** – Rhabdomyolysis
- Lactic acidosis, Nausea, vomiting

```
CARBOXYHEMOGLOBIN
```

- – Pulse oximetry is unhelpful
- – Levels quickly improve with Oxygen therapy and levels measured after oxygen therapy may not relate with toxicity
- – Level - above 3 is significant in non smokers (above 10 in smokers), ***Above 30 is severe***

```
TREATMENT
```

1. Scene safety, removal
2. MONITOR

- Check levels
- Check ABGs and CO Oximetry, ECG
- Serum Lactate

3. ABC and supportive care
4. 100% Normobaric Oxygen, and supportive care

- ***Indications of Hyperbaric oxygen*** - Coma, MI, PREGNANCY, EXTRAPYRAMIDAL FEATURES, Carboxyhemoglobin Level above 25%
- – – – (***Antidote*** – not available in most countries – ZINC BISVINYLIMIDAZOLE DIACETATE)

```
METHEMOGLOBINEMIA
```

- When Ferrous iron in hemoglobin is oxidized to Ferric iron.
- can be due to anesthetics, Antibioticss, antimalarials, Industrial alanine dyes
- Less than 10% is usually asymptomatic
- Cyanosis appears when it is more than 10% (Pathognomonic ***Chocolate brown blood***)
- More than 50% ➡ high likelihood of Seizures, Arrhythmias, Coma
- Cyanaosis and low Oxygen saturation with normal PaO2

- Normal po2 with met Acidosis

```
MANAGEMENT
```

- Remove causative agent
- Give 100% Oxygen
- Supportive Care – i.v line, Cardiac monitoring, Treat seizures if present
- ***First line antidote*** – METHYLENE BLUE 1-2mg/kg i.v in 5 minutes (and may repeat once after 1 hour)
- – – – INDICATIONS – methemoglobinemia above 20-30% (or at lower level if symptomatic
- ***Second line Antidote*** – (if methylene blue unavailable) – ASCORBIC ACID 1-2 gram i.v (Vitamin C)
- ***RESCUE THERAPY*** – Exhange transfusion and consider hyperbaric oxygen in refractory cases

---

OP POISONING

- Cholinesterase inhibitor - increase acetylcholine levels
- for treatment - cholinesterase activator - Pyridostigmine
- ***High risk groups*** – Farmer, pesticide and insecticide handlers

```
FEATURES
```

1. ***Muscarinic*** – *(Parasympathetic)* - **SLUDGE** (Salivation, Lacrimation, Urination, Diarrhea, GI Cramps , Emesis) and Miosis, bradycardia, Hypotension
2. ***Nicotinic and Musculoskeletal*** - Muscle fasciculations, cramps, tachycardia, hypertension, Dilated pupils
3. ***CNS*** – confusion, agitation, seizures, Coma
4. ***CVS*** – bradycardia is muscarinic effect, Tachycardia is nicotinic effect

```
INVESTIGATION
```

- ECG - Torsades de ponte
- CXR - Aspiration
- OXIMETRY

```
MONITORING
```

- Cholinesterase activity
- Heart Rate

```
TREATMENT
```

1. Scene safety and decontamination
2. Wear PPE
3. ABC and Supportive Care - i.v fluids, Vasopressors for Hypotension, BDZs for seizures
4. ***MUSCARINIC ANTIDOTE IS ATROPINE*** – *(Reverses muscarinic effects, not nicotinic effects)*.
5. ***NICOTINIC ANTIDOTE IS PRALIDOXIME*** (CHOLINESTERASE ACTIVATOR)

- – – – Improves nicotinic symptoms - (neuromuscular symptoms)
- – – – IN ADDITION TO ATROPINE, GIVEN ASAP, Early administration is critical
- – – – 2gm stat in 30 minutes then continuous infusion at 500-750mg/hour for 3-7 days

6. if Develop torsades - MgSO4 is given

```
ATROPINIZATION
```

- Target is DRYING OF RESPIRATORY SECRERIONS , aiming to clear bronchorrhea and crackles
- Heart rate above 80 but this is secondary sign
- pupil dilation is not a reliable sign
- – – – *(EVEN IF HEART RATE IS UPTO 150, SHOULD GIVE ATROPINE - GIVE IN DILUTIONAL FORM)*

- – – – Atropine bolus, (initial 2-4mg, which is doubled after every 5 minutes if target not achieved), are given till *ATROPINIZATION* and after achieving the target, start i.v infusion (typically infusion dose per hour is 10-20% of total dose needed for achieving Atropinization)

- Theoretically, in OP poisoning, we can not ***Over Atropinize*** the patient. Massive doses are required and should be aggressive. ***In severe cases, Atropine total dose needed may be in Grams***

```
DRUGS TO AVOID
```

- Frusemide - will ppt Arrhythmias, dehydration

- Beta Blockers - bradycardia risk

- Aminoglycosides - cause neuromuscular blockade, and prolong QT

```
DDs
```

- Over treatment of Cholinergic crisis

- NMS, Serotonin syndrome, Amphetamine, Nicotine Toxicity

- Botulism

```
SYNDROMES in OP Poisoning
```

1. ***Intermediate Syndrome***

- Develops in 20% of hospitalized patients, in 1-4 days and improve in 2-3 weeks – *(proximal muscle weakness, Cranial Nerve palsies, respiratory muscle paralysis)*

2. ***Delayed neuropathy*** - develops after 2-4 weeks – *(Axonal neuropathy, distal weakness, sensory loss)*
3. ***Long term*** – develop after months – *(cognitive impairment, Parkinsonism)*

LEAD POISONING

- BATTERY WORKER, Mining, Foundaries, PAINTER, Old housing

1. ***Blood*** - Anemia, basophilic stippling
2. ***CNS*** - Headache, Memory loss,

3. ***Motor neuropathy*** – foot drops, wrist drop, flaccid paraparesis

- – – – *Lead Neuropathy is predominantly motor* - wrist drop, foot drops (Arsenic NP is mixed)
- Blue lines on gums
- Hyperkalemia due to RTA 4

```
INVESTIGATIONS
```

- CBC with Peripheral film
- serum lead Level (toxicity comfirmed if it is above 3.5 microgram/dl)
- CT BRAIM – *(if Encephalopathy, seizures, focal deficit)*

```
TREATMENT
```

- Nutritional support with Iron, Calcium, Zinc, and Vitamin C
- ***Chelation therapy*** – is specific treatment, but usually not indicated for mildly elevated levels

1. Succimer - (DMSA) – Oral – specifically for children
2. Combined treatment with Dimercaprol and Calcium disodium EDTA

- – – – Dimercaprol given first, then Calcium Disodium EDTA at a different site
- – – – ***Dimercaprol*** i.m - 4-5 mg/kg i.m 4 Hrly for 5 days
- – – – ***Calcium Disodium EDTA*** – i.m or i.v 75mg/kg/Day for 5 days

```
DDs
```

- AIP - psychiatric symptoms
- FMF - recurrent serositis
- Lead Poisoning
- Mercury neuropathy is mixed
- Arsenic
- All causes of flaccid paraparesis

ARSENIC POISONING

- pesticides, rusted pipes,

1. ***Acute*** – (within minutes to hours afters exposure)

- GI features are most common. vomiting, pain, Rice-Water diarrhea, Bloody Diarrhea
- Hypotension,
- Cough, Dyspnea, Chest pain

2. ***Subacute*** – (1-3 weeks after exposure)

- Sensorimotor neuropathy
- Cytopenias
- ***Mee lines*** - transverse white lines on nails

3. ***Chronic*** – (Months to years after exposure)

- Dermatological features are hallamrks – Hyperpigmentation (raindrop appearence), HYPERKERATOSIS OF PALMS AND SOLES

- Neuropathy

- Hypertension

- Portal hypertension, Liver cirrhosis

- Bone marrow suppression

- cancer risk

```
MANAGEMENT
```

- ***chelation therapy*** is specific treatment

1. Scene safety and removal
2. ABC and supportive care – e.g. for neuropathic pain, seizures and hemolysis
3. GI Decontamination if recent exposure – Lavage, whole bowel irrigation
4. ***Dimercaprol*** is first line
5. ***Succimer*** – (DMSA) – oral chelator

- – – severe cases may need sequential or combination chelation therapy with Dimercaprol and Succimer

6. Dialysis – indicated if renal failure or if RFTs are impaired

MERCURY POISONING

- ***inhalation*** — CLASSIC TRIAD of Coarse teemors + shyness/social withdrawal + Gingivitis

- ***Chronic dietary exposure*** – Paresthesia, dysarthria, Ataxia, tunnel vision and hearing problem

- ***Systemic effects*** – (regardless if exposure is by inhalation or dietary) – Cardiomyopathy, Anemia, Autoimmune disorders, Thyroid dysfunction

```
MANAGEMENT
```

1. Scene safety, source removal, decontamination
2. ABC and supportive care
3. Chelation

- – with ***DIMERCAPROL***
- – or with ***SUCCIMER***

4. Dialysis – if impairment of RFTs

ALCOHOL

- BDZ in withdrawal
- Disulfiram for abstinence - inhibit acetaldehyde dehydrogenase - unpleasant features headache nausea flushing
- Acamprosate for abstinence
- – Metabolism
- Alohol - Acetaldehyde (by alcohol dehydrogenase - Acetate (by Acetaldehyde dehydrogenase)
- Methanol - Formaldehyde (by alcohol dehydrogenase) - Formic Acid (by aldehyde dehydrogenase) – Formate causes severe metabolic acidosis and snow field cataract
- – ***High Anion scenario in Alcohol use***
- Methanol
- Ethylene
- pancreatitis
- liver failure

ALCOHOL WITHDRAWAL

- ***Chronic alcohol use*** ➡ increases GABA and inhibits NMDA-glutamate receptors
- Withdrawal - opposite happens
- **Symptoms**
- start at 6-12 H
- ***12 Hours *** - Hallucinations - *(auditory, Visual, Tactile)*
- ***36 Hours*** - Seizures peak 36H
- ***72 Hours*** - Delirium - give oral lorazepam as 1st line.
- – palpitations, Nausea, Vomiting, *Sweating, flushing, Hyperthermia, tachypnea, DILATED PUPIL*
- ***Treatment***
- BDZ are most effective
- Carbamezipine is acceptable alternate
- Will also need Thiamine

WERNICKE

- – mnemonic **CAN**
- Confusion (Enceph)
- Ataxia
- Nystagmus, LR palsy, Conjugate gaze palsy
- – Areas involved are Peri aqueductal, Periventricular, Subthalamic, Mammillary
- – ***Investigation*** - Red cell emzyme transketolase
- give iv thiamine
- reversible if given thiamine in time. otherwise progress to Korsakoff, has confabulations
- – Dextrose depletes thiamine - should never be given before Thiamine

ETHYLENE POISONING

- ***involves kidney***
- antifreeze, mechanic, suicidal
- – Stages

1. like alcohol intoxication - confusion, slurring, coma
2. HAGMA , hyperventilation, Hypocalcemia, Tachycardia, Hypertension
3. Deposition of Calcium Oxalate crystals around 12 H – Renal - stones, respiratory, cardiac failure

- – **(TREATMENT)**
- Ethanol
- Fomepizole
- Dialysis

METHANOL POISONING

- (***Involves Eyes***)
- more than 30mg
- HAGMA with high Osmolar Gap, Vision symptoms
- Alcoholic, bing drinking ➡ Confusion, headache, *CEREBELLAR symptoms, DECREASED VISION WITH POORLY REACTIVE PUPIL*
- – Features of alcohol intoxication + HAGMA with high Osmolar gap
- – Retinal injury + Optic neuropathy
- ***INVESTIGATIONS***
- Eye examination
- CBC, RFTs, LFT, Amylase, MRI
- ABGs
- Visual Evoked Potentials for neuropathy
- ***TREATMENT***
- Supportive, admit, Fluids, bicarb
- Pyridoxine, Thiamine
- Seizures - Diazepam
- – Fomepizole or Ethanol (delays methanol metabolism and excretion)
- – Folic Acid
- – Dialysis (if low GCS, methanol above 0.5gm, Renal or Visual impairment, Acidosis not correcting with bicarb)

COCAINE

- ***CVS*** - HTN, Brady or tachy, MI, dissection, long QT
- ***CNS*** - Dilated pupil, hypertonia, hyperreflexia, seizures
- Hyperthermia, Rhabdomyolysis , Met Acidosis, renal failure
- ***Management***
- BDZ are 1st line
- Chest pain - BDZ + GTN - PCI
- HTN - CCB
- Avoid BB, because then unopposed alpha activity will cause further vasospasm

AMPHETAMINE

- Features are same like cocaine , BP, Chest pain
- management options include Nitrates, BDZ , PCI

ECSTASY *(MDMA)*

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FEATURES
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- ***CNS*** - Anxiety, confusion, ataxia, *DILATED PUPIL*
- ***DIC*** , Rhabdomyolysis - Renal failure
- ***CVS*** - high rate high BP
- Hyperthermia, Hyperventilation
- ***HYPONATREMIA*** - MDMA stimulate ADH - less urine output - meanwhile too cool down Hyperthermia pt drink excess water ➡ Hyponatremia

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TREATMENT
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- supportive and ***DANTROLENE***

SMOKING CESSATION

- Nicotine replacement therapy

1. ***Vernicillin*** - partial agonist of nicotine receptors

- started 1 week before target date of smoking cessation - given for 12 weeks
- Can’t give in pregnancy or nursing

2. ***Bupropion***

- nicotinic antagonist
- started 2 weeks before target date of smoking cessation
- can’t give in pregnancy nursing or epilepsy
- ***pregnancy***
- cognitive behavioral therapy, motivation support
- nicotine replacement therapy.

BETA BLOCKERS TOXICITY

1. Resp - Wheezing, Spasm
2. CVS - brady, hypotension
3. CNS - delerium, seizures
4. Metabolic - Hypoglycemia

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MANAGEMENT
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- Fluids, Nebulize
- Atropine
- Iv glucagon
- Lipid emulsion Therapy

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    DDs
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- Shock
- Organophosphate poisoning
- Digoxin toxicity

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1. **Acidosis with high lactate*** - Metformin, Ferrous sulphate, Cyanide, carbon monoxide
2. ***Methanol*** - HAGMA with high Osmolar gap,
3. ***Mutlidose activated charcoal*** used in - Carbamezipine, Dapsone, Phenobarbitone, Quinine, Theophylline
4. ***Whole Bowel Irrigation*** used in - Ferrous, Lithium, Drug packets
5. ***SODA BICARB*** used in - Salicylates, TCA
6. ***Mucosal ulceration*** feature of - Paraquat poisoning

ANTIDOTES/MAINSTAY OF TREATMENT

- BDZ - Flumezinil
- OPIOIDS - Naloxone

- TCA - Bicarb
- CYANIDE - DiCobalt EDETATE
- CO - 100% or Hyperbaric oxygen
- BB - Atropine, Glucagon, Lipid emulsion
- OP - Atropine, Pralidoxime
- Lithium - bicarb, dialysis
- Ethylene - Ethanol, Fomepizole
- Methanol - Ethanol, Fomepizole
- Salicylate - bicarb, dialysis
- Paracetamol - acetylcysteine/methionine, Transplant

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POISONINGS
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LITHIUM

- ***Kidney*** - Nephrogenic Diabetes Inspidus, FSGS, AKI
- ***Thyroid*** - Hypothyroidism
- ***CNS*** - Coarse Tremors, dysarthria, nystagmus , Hyperreflexia
- ***CVS*** - Low BP, brady, Blocks, Prolongation of PR or QT

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MONITORING
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- – (for patients taking regular doses) – Thyroid and RFTs 6 monthly
- – Lithium levels (draw sample after 12 hours after the dose)
- – – ***Mild-Moderate toxicity*** – levels 1.5-2.5 mEq/L
- – – ***Severe toxicity*** – levels above 2.5 mEq/L
- ***FINE*** tremors in chronic toxicity, ***COARSE*** in acute toxicity (***side note*** – cyclosporine - coarse tremors)
- Other important points – High Calcium, Low Mg, weight gain

```
TOXICITY
```

- ppt by dehydration, diuretics, renal failure
- NSAIDs, ACE, CCB, MNZ, MTX

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MANAGEMENT
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- Gastric lavage or whole bowel irrigation
- give fluids

- alkalinization of urine
- then hemodialysis (at level above 4, or CNS or CVS features)
- – ***Charcoal is ineffective***
- – ***Lithium contraindicated in Myasthenia and Psoriasis***

DIGOXIN

- used in AFib for rate control (slows AV conduction and stimulate Vagus nerve)
- for inotropics effect (inhibit Na/K ATPase), improves symptoms in failure but doesnt improve mortality
- first order kinetics half life 1.6 days. 25% of plasma drug is protein bound.

```
LEVELS
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1. Therapeutic range = 0.5-0.9 nanogram/ml
2. Toxicity = usually above 2 nanagram/ml

```
TOXICITY
```

- ppt by

1. ***hypo*** (kalemia, mg, thyroid, thermia)
2. ***Hyper*** (natremia, calcemia)
3. ***Drugs*** (Amiodarone, Verapamil, Beta Blockers, Spironolactone, SSRI, drugs causing Hypokalemia - thiazide and loops)
4. ***Systemic diseases*** – (CKD, MI, Hypothyroidism
5. Advanced age

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FEATURES
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- ***GIT*** (Nausea, vomiting) – *usually the earliest symptoms are GI-symptoms*

- ***CNS*** (Headache, Dizziness, Irritability, yellow vision)

- ***CVS***

- Arrhythmias - could be almost any type

- ECG - PR prolonh, QT shortening, reverse tick down slopping ST depression, inverted T, Tachy brady arrythmias)

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MANAGEMENT
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1. stop the drug, treat the ppt factor, Give phenytoin or lidocain
2. Keep Potassium in range of 4-5.5
3. ***if present*** – Correct Hypercalcemia, Hypernatremia, Hypomagnesemia,
4. Digixin Specific Antibody -+ (Digiband)

- – – if BP unstable, Arrythmia (persistent brady or vent Arrythmias), Potassium above 5, Digoxin level above 13nmol, ingestion more than 10mg)

5. General measures - Charcoal, etc

- – Amiodarone contraindicated
- – Shock only considered when all else has failed
- – ***Side note*** - (digoxin contraindicated in amyloisdosis)
- – ***Digiband*** - *exact dose is calculated by serum level, Ingested amount and body weight. if none specified, then in acute toxicity empiric adult dose is 10-20 vials of 40mg, and in chronic toxicity 6 vials of 40mg, prepared in sterile water then diluted in normal saline and given i.v over 20-30 minutes.* – may repeat, and commonly upto 20 vials are needed.

SALICYLATE POISONING

- For exam purpose, scenario usually focus on ABGs - ***mix disorder*** - First Respiratory alkalosis and then HAGMA (High Anion Gap Met Acidosis)

- ***Acute*** – ingestion of 150mg/kg

- ***Acute and severe*** – ingestion of more than 300mg/kg

- ***Chronic*** – Repeated high dose intake

```
PRESENTATION
```

- ***Resp*** - Tachypnea, hyperventilation, Non-Cardiogenic Pulmonary Edema

- ***CNS*** – Tinnitus (early), Deafness, Seizures, cerebral edema, coma
- ***GIT*** - Nausea, Vomiting, Pain
- ***Electrolytes*** - Low potassium
- ***Others*** – Sweating, Hyperthermia, Rhabdomyolysis, Thrombocytopenia, DIC
- ***RBS*** - can be high or Low

```
INVESTIGATIONS
```

- Serum levels
- ABGs - ***pH close to normal, HCO below 18, CO2 below 35***
- CBC, LFT, RFT, RBS, Electrolytes
- Urine pH

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TREATMENT
```

1. ABC
2. charcoal if in 1-2 hours – 1gm/kg

- – – *Can also consider Multi-Dose activated charcoal*

3. urinary alkalinization

- – – if level 450-700 (bicarb but ***NEVER*** in cerebral and pulmonary edema)
- – – ***Target*** - Urine pH 7.5-8.5 and Serum pH 7.45-7.55

4. ***Dialysis***

- – – (If involvement of Kidney, heart, CNS)
- Serum level above 700
- Resistant Met Acidosis
- AKI
- Pulmonary Edema
- CNS

```
MONITORING
```

- Urine pH - keep above 7.5
- Urine output - more than 1ml/kg/Hour
- Drug level (in mg/L) - below 250 is mild, 250-500 is moderate, 500-700 is severe, above 700 is fatal
- Electrolytes 2-4 H
- – ***level 450-700 mg/L (or 45-70mg/dL*** ➡ Urinary alkalinization – give soda bicarb
- – ***Level above 700 mg/L (or 70mg/dL*** ➡ dialysis
- – *Chronic toxicity often has a lower threshold for dialysis - like 600mg/L (or 60mg/dL)*

PCM OVERDOSE

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PHASES
```

1. ***0.5-24 Hours*** – Nausea, Vomiting
2. ***24-72 Hours*** – Abdominal pain, Hepatomegaly, Oliguria
3. ***72-96 Hours*** – Jaundice, Coagulopathy, Encephalopathy and hypoglycemia
4. ***4 Days to 02 weeks*** – Recovery (if patient survives), or progression to death

```
IMPORTANT POINTS
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- dose more than 150mg/kg (or 8-10gm in 24 hours) or Repeated Supratherapeutic doses (more than 4gm/day for more than 48 Hours), ***staggered*** - excessive dose over 24 hours
- – – risk increased if Anorexia nervosa, Alcohol, HIV, taking p450 inducers, Hepatotoxic drugs
- – – Check levels at 4 hour, not earlier
- – – *Normal conjugation is glucoronic acid, when this is saturated, then oxidation occurs - NABQI accumulation which is toxic - conjugation then with glutathione - when glutathione consumed - toxins bind with cell proteins - Oxidative stress - mitochondrial injury and eventually cell death*

```
INDICATIONS FOR ACETYLCYSTEINE
```

- (precursor of glutathione)
- Hepatoprotective if started within 8 Hours

1. if PCM taken in ***Staggered dose***
2. ***4 hour level above 100 or 15H level above 15mg/L***

- IV Given as slow infusion in 5% dextrose (150mg/kg in 250ml in 1 hour, then 50mg/kg in 500ml in 4Hr, then 100mg/kg in 1 Litre in 16 hours)
- ORAL 140mg/kg, then 70mg 6 hourly 17 doses
- Side effects - Nausea, vomiting, itching, Urticaria, Hypoglycemia, ANAPHYLAXIS, HYPOTENSION
- ***if minor side effects*** - stop, give Antihistamine and restart
- ***if Significant allergic reactions to acetylcysteine*** - (anaphylaxis, hypotension) – then METHIONINE oral can be used

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LIVER TRANSPLANT
```

- (Referral if INR above 2 @ 48 hours, or above 3.5 @ 72 hours)

1. ***pH*** below 7.3, after 24 Hours , or after resuscitation (or lactate above 3.5 after fluid resuscitation)
2. ***All three*** of (PT above 100, Creat above 300, Encephalopathy grade 3-4)

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TRANSPLANT IN OTHER POISONING
```

- 1. – INR above 6.5
- 2. – 3 of these 5
- age less than 11 or more than 40
- INR above 3.5 – (or PT above 50 seconds)
- bilirubin 300 micromol/l – (***approximately 18mg/dl***)
- Jaundice to encephalopathy gap less than 7 days
- Non-A Non-B Hepatitis, idiosyncratic drug reaction

- – – – ***Drug toxicity DDs*** - *infection - Hepatitis, leptospirosis, Metabolic Encephalopathy, Ethylene Glycol*

BDZ OVERDOSE

- BDZ potentiate inhibitory affects of GABA by facilitating its binding to receptors ➡ Slurred speech, ataxia, Altered Mental Status

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MANAGEMENT
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- – Supportive and Flumezinil (though its not used commonly due to side effects like SVT, and seizure)

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PROPYLENE GLYCOL POISONING
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- it is diluent used in iv preparations of lorazepam and diazepam and it should be kept in mind that side effects after these iv injections could also be due to Propylene Glycol ➡ Tissue necrosis, hemolysis, Arrythmias, multiorgan dysfunction

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OPIOIDS POISONING

- ***Mu*** - Analgesia, Euphoria, brady, GI dysmotility, Resp depression
- ***Kappa*** - Hallucinations, Miosis
- ***Delta*** - Pain and mood
- – – – Opioid effects (pain relief and side effects like respiratory depression, addiction) are primarily due to agonistic effect on ***Mu Receptors***

```
FEATURES
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- ***CNS*** – Lethargy, Sedation, altered sensorium, coma, Miosis
- ***Respiratory*** – Bradypnea, Hypoventilation, Apnea, Non-Cardiogenic Pulmonary Edema, Respiratory Arrest
- ***CVS*** – Bradycardia, Hypotension, Arrhythmias, Arrest
- ***GIT*** – Gastric aperistalsis (Nausea, Vomiting, Constipation)
- ***Others*** – Urinary retention, Pruritus, Flushing, Hypothermia

MANAGEMENT

- – ***ABC before antidote***
- – fluids
- – Acute - Naloxone 0.4-1mg - can repeat in 3-5 minutes (may need upto 20mg dose) – ***Target*** – Adequate Ventilation
- – ***no iv access** - give 2mg i.m
- – Chronic/dependance - Naltrexone